Assessment of Circumstances Facing Contemporary Families in South Africa

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AJM, TX & DS

ACRONYMNS

ASRP African Social Research Programme
DoH Department of Health
EC Eastern Cape
FGD Focus Group Discussions
IDI In-depth Interviews
KZN KwaZulu- Natal
NGO Non-governmental Organization
NHA National Health Accounts
OVC Orphaned and Vulnerable Children
RA Rapid Appraisal
SPSS Statistical Package for the Social Sciences
SSI Semi-structured Interviewing
STD Sexually Transmitted Disease
STI Sexually Transmitted Infection
UNFPA United Nations Population Fund

EXECUTIVE SUMMARY

The Study

The study presented in this report is part of a larger research project entitled *Understanding the changing family composition and structure in South Africa in the era of HIV/AIDS pandemic*. The project investigates the type of families existing in South Africa, the pressures those families face in the light of the HIV/AIDS epidemic, the changes that have occurred overtime
and the coping mechanisms. This report presents findings obtained in phase 1 which is a socio-cultural study that is exploratory in nature.

Methodology

Qualitative data were collected using a semi structured interview guide in three provinces of South Africa by conducting focus group discussions as well as individual in depth interviews. People who were interviewed were Africans who speak IsiXhosa (Eastern Cape), IsiZulu (KwaZulu-Natal), Tshivenda and Sepedi (Limpopo). Altogether, 283 individual in-depth interviews and 120 focus group discussions. The total number of respondents is 1,096 (335 males and 761 females), some as young as 12 years old and the oldest was 90 years old.

Results

Changes in Family Structures

The most common types of families that existed in different areas included the nuclear and extended families. Other families listed were skip-generation families which consisted of grandparents and grandchildren, child-headed families where children are staying alone without an adult member, as well as single parent families which consist of the mother staying with her children. There was an indication that there was an increase in the following three types namely skip-generation, child-headed and female-headed families. When it comes to headship, culturally men were considered to be heads of families mainly because they are the ones who lay down

rules that should govern other members of the family and due to the fact that they are working and provide for the family. Women were only considered to be heads if they do not have husbands.

Migration and Mobility

People felt that these days there is a change in the patterns of migration and mobility because both men and women seek work far from home. Some females mentioned that men who migrate put their partners at risk of being infected with sexually transmitted infections including HIV because they form extra marital relationships at their places of work. It is interesting to note that they did not mention the fact that some female partners back home might also be involved in those kind of affairs which might put their migrant partners at risk. It was also reported that at times families dissolve because of staying apart for extended periods of time due to migration. Some families are deserted by their breadwinners who work far away since they start new families in the cities.

Sexual and Reproductive Health Awareness

There is an indication that premarital sexual relations, though highly frowned upon by parents and the older generation, remain very common among young people. The knowledge of sexually transmitted infections is widespread though there are still considerable misconceptions about the diseases and especially about HIV/AIDS. The knowledge of the condom is also still shrouded in myths especially those to do with the origin of the HIV infections, and the powerlessness with which to demand that one is used is still a drawback in the fight against the epidemic. It is indicated in the transcripts that discussions between parents and their children are still in the form of parents 'telling' their children what not to do and dictating to them the consequences using 'frightening' techniques. While advice on the use of family planning is available through the clinics, there is still room for improvement in the services of such facilities.

Access to Health Services

The exclusion of Africans from services provided by the State has led to the shortage of information on how to prevent illnesses and diseases and how to control them once one contracts them. The long distances people travel to available facilities, the overcrowded facilities and the shortage of essential medicines colour people's image of the health services being provided to them. Despite the strides taken by the Provincial Governments in addressing some of the backlogs in health provision, many people remain without proper access to health information, appropriate health facilities and funds to take themselves to services where services are too far from their places of residence.

Illness and Death

There is a concern that in some communities many people seem to have reached a point of reckless disregard for their own health and lives as well as those of others. In addition, some intervention is necessary to turn around the entrenched imperative that people have to spend their life-time savings only to provide a funeral for one of their members. Most of the money is spent on non-essential frills such as the cost of keeping the body at the mortuary, the cost of the coffin, the cost of food and even the cost of renting buses which take people to and from the cemetery. A lot of this unnecessary expenditure seems to be justified as part of tradition. But one does not have to think very far into the past to imagine how all of this could have been done.

Care and support

As stated above, there exist child-headed families and skip-generation families. Some child-headed families receive financial support from members of their extended families who work. At some point those who are struggling to get any kind of support go to the extent of getting involved in prostitution especially young girls. The role of the extended family in taking care of child-headed families is weakening. Unfortunately children who live on their own do not qualify for the child support grant. It seems those families that are headed by grandparents are better off because they survive on an old age pension. But, some grandparents who were heading families

were not old enough to qualify for such a grant. There was wide acknowledgement of the government support from most participants with concerns that the grants are not entirely enjoyed by the intended recipients. Thus some people thought that old age pension and child support grants are misused by many recipients.

Recommendations

Child Headed Families: A voucher system should be introduced to assist children who are taking care of their siblings. They need to be given vouchers instead of money for buying food and clothes as well as to pay for other essentials.

Skip Generation Families: Unemployed grandparents or those who do not qualify for a pension fund because they are not old enough, and yet they are looking for their grandchildren, should be considered for a financial support. It is also important to note that both child-headed and skip-generation families need emotional and psychological support as well as guidance.

Cohabitation: Measures should be established to encourage people to have formal marriages such as reducing the amount of *lobola.* We argue that proper negotiation with traditional leaders can go a long way in making sure that people understand the concept of *lobola* and hence accept small amounts of money or contributions in kind. In cases where cohabitation has to continue, there should be a mechanism to formalize those relationships especially if people cohabit for an extended period of time.

Cost of Funerals: Living standards and the quality of life of surviving members of the family is adversely affected because of the high cost of taking care of people living with HIV/AIDS. Measures should be taken to reduce the cost of funerals. These can be done by encouraging people to conduct funerals as soon as possible.

Care and Support for HIV/AIDS Affected Families: The study has found that people have adequate knowledge of HIV/AIDS. There is now a greater need to concentrate on issues related to care and support to families that have been affected.

Changing Sexual Behaviour: Many people do not practice safe sex even if they know the consequences. In other words, the behaviour of having multiple partners still exists and many do not want to use a condom. The special group to target in dealingwith HIV/AIDS is perhaps migrant workers.

CHAPTER ONE

INTRODUCTION

1.1 Background

The Republic of South Africa, with an estimated population of 44.8 million in October 2001 (Statistics South Africa, 2003), is the economic power house of sub-Saharan Africa and has rapidly become a political leader in the region during the last 5 years. The labour force catchments area that services its economy spans the whole southern African region. Such achievements have not been without social costs. One of the social costs was that borne by families. The exploitation of Africans by first the colonial administrations and later by apartheid administrations undermined the economic, social, cultural and political basis of African life.[1] The difficulty of eking out a living led many (able-bodied men, initially and then later, women) to leave rural areas for the promise of employment in the mines and cities of South Africa. While such large-scale migration partially satisfied the economic imperatives, the social upheaval that it produced is felt to this day.

By and large, to enable businesses to make as much profit as they could, the wages of Africans were kept low through various laws. Because some rural areas have fertile soils and adequate rainfall, some people managed to support their families from such low wages. However, the economic downturn that started in the mid 1970s and deepened in the late 1980s saw many lose their employment as well as the meagre wages, which had enabled them to support their families. The economic downturn would not have been as devastating had it not been accompanied by the worst drought in decades, which engulfed large parts of South Africa from the mid 1980s. The impact of the loss of employment and drought in rural areas was felt most strongly by families. The social fabric which constituted and had, up to then, held families together was stretched to the limit at this stage.

[1] The classification of population group into four categories that is used in this report was adopted from Statistics South Africa (2003), namely, Black African, White, Coloured and Indian or Asian.

From the 1990s to date, the economic situation remained precarious. The 'globalisation' of the South African economy brought some advantages to the country as well as some disadvantages. While some foreign exporters seem to have done well during this period, many labour intensive operations (such as the mines and the garment industry) struggled and some did not survive. This saw large numbers of people lose their employment in an economy that was growing without creating much employment. Families struggled as large numbers of people became permanently unemployed and many lived without a single source of reliable income.

Added to the impact of migration and unemployment, the families had to contend with the outbreak of the HIV/AIDS epidemic. HIV/AIDS descended upon South Africa quietly at the time when a different battle (that is the war against apartheid political system of governance) had captured the attention and energy of the whole population. Sandwiched and crushed steadily between apartheid political, social and economic systems the family was forced to go through structural transformation. The impact of this epidemic has been very detrimental to the welfare of the remaining members of the family.

The social impact of previous economic, social and political policies on families in South Africa has been such that marriage is no longer a precursor of the establishment of families. Migration had the effect of moving people away from their families for long periods of time. Among some of the effects of such extended stays away from home was the strain felt by nuclear families partly as a consequence of the establishment of relations with people found in urban areas. Many nuclear families did not survive the impact of such forces. Generally, men left to work in urban areas, leaving their wives with children in rural areas. The existence of extended families ensured that many such families were able to survive. In some cases, both parents left to find work in urban areas, leaving either the grandparents or relatives to look after the children; thus creating families whose members live in different places (scattered families), families that have only the elderly with their grandchildren living

together (skip-generation families) or families that comprise of different generations in some cases with unrelated people who are living together (complex families).

The study presented in this report is part of a larger research project entitled *Understanding the changing family composition and structure in South Africa in the era of HIV/AIDS pandemic*. The project intends to investigate the type of families existing in South Africa, the pressures that families face in the light of the HIV/AIDS epidemic, the changes that have occurred over time and the coping mechanisms. The project, which is implemented as part of the African Social Research Programme of the United Nations Population Fund (UNFPA) uses both qualitative (phase 1) and quantitative (phase 2) approaches. This report presents findings obtained in phase 1 of the project. It involves conducting focus group discussions and individual in depth interviews with people in three provinces of South Africa namely: KwaZulu-Natal (KZN), Eastern Cape (EC) and Limpopo (formerly known as Northern Province – NP).

1.2 Objectives

Phase one is a socio-cultural study that is exploratory in nature. Since there are very few similar studies that have been conducted in South Africa, this phase aims at collecting baseline information which will assist in understanding the family and hence use this information in planning for the second phase. The specific objectives for phase 1 are:

- to understand the different processes of family formulation;
- to investigate different types of families that exist;
- to examine the socio-cultural factors that affect families;
- to explore how people perceive illness and deaths in the era of HIV/AIDS;
- to explore the impact of HIV/AIDS on the family;
- to assess the use of reproductive health services especially by young people;
- to examine the pros and cons of government grants;
- to assess the coping mechanisms in different types of families; and
- to provide baseline information for the quantitative study.

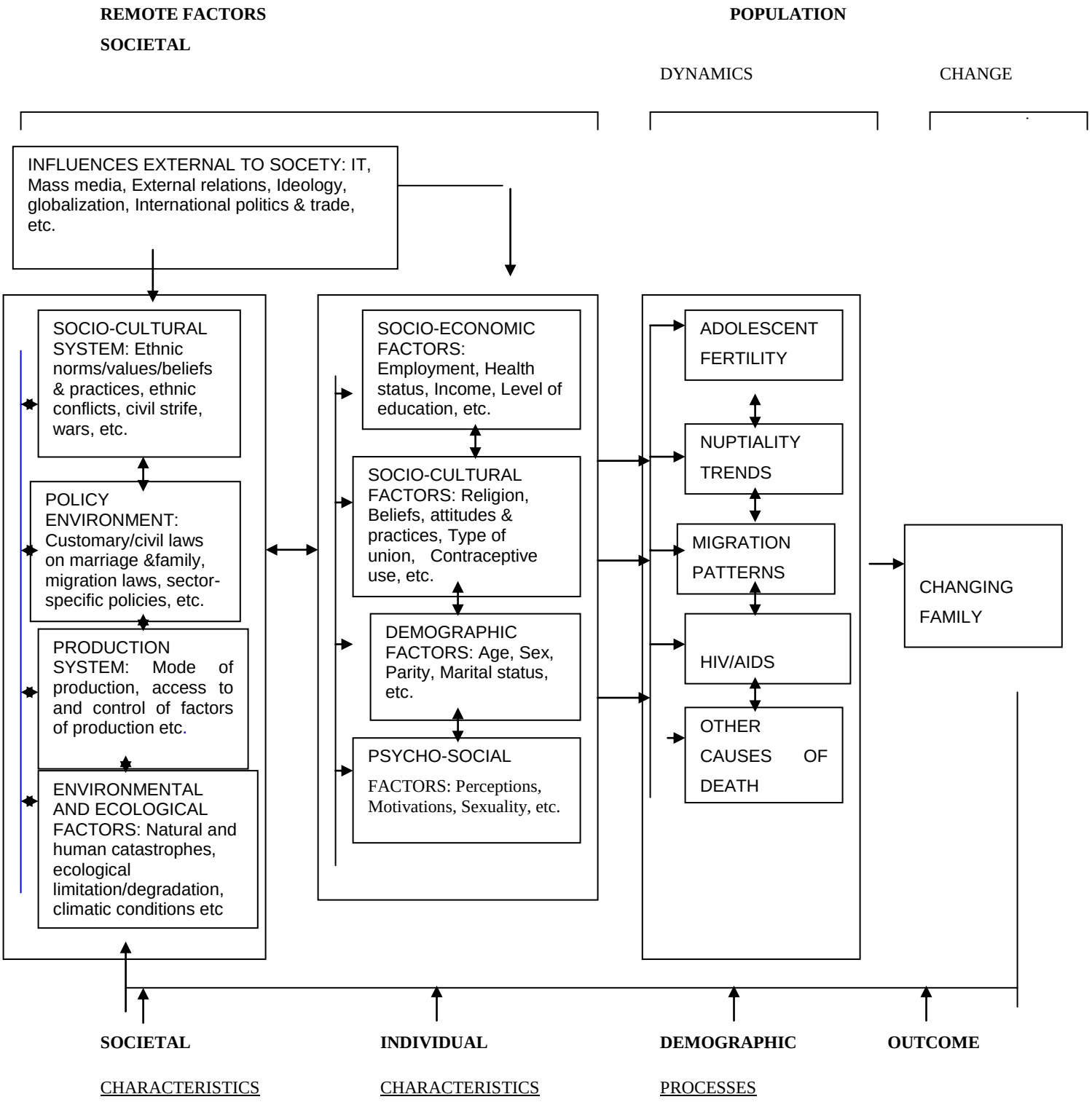
1.3 The Conceptual Framework

The study uses the conceptual framework that was developed by the African Social Research Programme (ASRP) for the purpose of studying the changes taking place in the African family (African Social Research Programme, 2002). The framework is presented in Figure 1.1. The block of **societal level factors** exert an important indirect influence on social and demographic processes. Major variations in levels and trends of fertility, mortality and migration cannot be explained without considering changes in societal level factors. Societal level factors are those which define the context within which communities, families and individuals find themselves. These factors typically include: socio-cultural systems, policy environment, production systems and environment and ecological factors.

In this framework the **individual factors**, which have been identified, fall into four categories, namely socio-economic, socio-cultural, demographic and psychosocial. Most of these factors have been used in many studies. This conceptual framework recognizes their theoretical basis. The individual characteristics, along with the societal/community level factors, constitute the remote determinants of social and demographic processes through which the society is transformed. The population dynamics as postulated in the ASRP framework apply to all three **demographic processes**, namely fertility, mortality and migration. In essence, they are those factors which mediate the influence of the characteristics of the society/community and of individuals in determining the occurrence of demographic events. Since the outcome is the African family, demographic processes have included HIV/AIDS and nuptiality trends.

The final stage of the framework i.e. outcome is the **changing family**. The socio-cultural perspective that has been incorporated in the framework, should contribute to the better understanding of the parameters of the cross-cultural encounters and the opportunities and challenges that these bring to policy responses and programmatic interventions in population and development.

FIGURE 1.: A Multi-level Dynamic Framework for the Analysis of Factors Related to Changing African Family



CHAPTER TWO

METHODOLOGY

2.1 Overview

Preparation for fieldwork was done in January and February 2003. It involved preparation of the interview guides, informed consent form and other important aspects of the training manual. All these were presented as a 26-page document entitled *Training Manual*. Planning for fieldwork was done separately for each province. With the help of collaborating universities, seven fieldworkers were recruited in each province of which one was the supervisor (see Appendix A1). Before fieldwork in each province, a three-day training workshop was organized aimed at understanding the approach of data collection used, research instruments, pilot study and discussing terms of reference for fieldworkers. The training was preceded by the translation of interview guides from English to local languages.

The pilot study for KwaZulu-Natal, which was conducted on 24 February 2003, took place in Botha's Hill near Durban. The actual fieldwork was conducted during the period 1 March 2003 – 6 April 2003. The pilot study for the Limpopo fieldwork was conducted on 23 March 2003, and the research team visited Ga-Dikgale village. The fieldwork for the Limpopo province took place during the period 26 March 2003 – 16 April 2003. The pilot study in the Eastern Cape was conducted on 7 April 2003 and the place visited was Ntselamanzi township about 10 kilometres from the University of Fort Hare. The fieldwork in Eastern Cape was conducted from 9 April 2003 to 27 April 2003. As dates show, there was overlap of the dates when fieldwork in the three provinces was conducted. Altogether fieldwork took a period of approximately two months.

2.2 Methodology

The methodology used in this study is called Rapid Assessment (RA). RA is a specific, more rapid, less costly qualitative research technique. RA is a way of learning from, and with, concerned respondents to investigate, analyse, and evaluate constraints and opportunities, and make informed and timely decisions regarding development issues. It is a method by which a research team can quickly and systematically collect information for: the general analysis of a specific topic, question, issue or problem; needs assessments; feasibility studies; identifying and prioritising projects and policy; and project or programme evaluations.

The purpose of RA is more to gain an understanding of the complexities of a topic rather than to gather highly accurate statistics on a list of variables. Moreover, in RA understanding qualitative nuances within a topic is just as important as finding general averages. RA methods would be used to obtain a differentiated understanding of the population's attitudes, beliefs, and behaviours towards a social issue. RA is applied most effectively in relatively homogenous communities which share common knowledge, values, and beliefs, although it has also been used in more complex urban environments. Its short duration and low cost also make it possible to carry out series of RAs with different groups of people rather than having to rely on the results of one large survey.

Semi-structured interviewing (SSI) is one of the main tools used in RA. It is a form of guided interviewing where only some of the questions are predetermined. RA interviews do not use a formal questionnaire but at most a checklist of topics/ questions as a flexible guide. In contrast to the formal survey questionnaire, many questions will be formulated during the interview. In the event that some topics/questions are irrelevant they can be skipped. Topics/questions usually come from the interviewee's response, the respondent's environment, observation of surroundings, and the RA team's

own background and experience. Two types of SSI approaches were followed: focus group discussions and individual in-depth interviews.

A focus group discussion (FGD) is a unique method of qualitative research which involves a homogenous group of people discussing a specific set of issues, problems or research questions. Focus groups are different from other methods of qualitative research in their purpose, composition and procedure. The purpose of a focus group is to explore the range of perspectives around a particular issue and to obtain detailed qualitative data from a predetermined group of people. The guide that was used for FGD is presented in Appendix A3.

The technique involves a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment. It is conducted with approximately seven to ten people. Two skilled research assistants (chair-person and notes taker) have to be present in each focus group. The chair-person follows prepared guidelines to introduce the issues to be discussed, asks open-ended questions to get the discussion underway, encourages participants to talk and interact with one another, and tries to keep the discussion on track. The notes taker takes notes and keeps track of what has been covered. Responses were audio taped and transcribed, with the transcripts serving as the data for analysis.

The second method used is individual in-depth interview (IDI). Information obtained from individual interviews is more personal than from group interviews, and is more likely to reveal other crucial information since respondents may feel they can speak more freely without fear of other people. Interviews are conducted with an opportunity sample of purposely-selected individual respondents. Interviewing a number of different respondents on the same topic quickly reveals a wide range of opinions, attitudes, and strategies. The bias of interviewing only one group of individuals must be avoided. It is advisable to ask individual respondents about their own knowledge and behaviour, and not what they think about knowledge and behaviour of others. The interview guide used for IDI is presented in Appendix A3.

2.3 Choice of Study Areas

Areas to be visited for fieldwork were selected separately in each province. It was necessary to take into account people of different background as well as covering a wide range of geographical areas. Given a wide range of factors affecting family composition and structures, it was decided that a range of three to five strategic areas should be selected from each province. When visiting the chosen places, neighbouring areas were also visited. It should be noted however that due to time constraints and the nature of this study, only African people were targeted in this first phase of the research project. People who were interviewed were natives who speak IsiXhosa (Eastern Cape), IsiZulu (KwaZulu-Natal), Tshivenda and Sepedi (Limpopo). Map1 presents the administrative provinces of the republic of South Africa along with locations of areas visited for fieldwork.

In KwaZulu-Natal province, five locations were chosen:

Jozini: Areas visited include Jozini City Centre, Makhanesi and Ophondweni. Jozini and the neighbouring areas are in the northern part of KwaZulu-Natal near the South Africa-Mozambique border. There is high mobility of people from one side of the border to the other. Nature of problems families have are unique in this place because of, among other things, the long distance from the provincial offices.

Estcourt: The places visited in Estcourt are KwaNokhesheni, KwaDlamini and KwaBhekabezayo. These areas are in Umtshezi Municipality along the Durban-Johannesburg highway (N3). They are all rural areas. Geographically, Estcourt is located in central KwaZulu-Natal.

Port Shepstone: The choice of Port Shepstone was guided by the fact that it is in the southern part of the province and near the coastline. In addition, it is near the Eastern Cape province. It was anticipated that many people in Port Shepstone and the surrounding areas will be internal migrants.

Greytown: Mbulwane and KwaCele are two villages that were visited in Greytown (a small town located in Umvoti Municipality in central KwaZulu-Natal). Both villages are located in the rural areas of about 45 minutes drive from Greytown. Greytown was chosen as a backup plan in case something goes wrong with other areas chosen.

Pietermaritzburg: The only urban centre chosen in KwaZulu-Natal province was Pietermaritzburg. The intention was to interview people from families that are located in urban settings and find out if their circumstances are different to those of people residing in rural areas.

For the Limpopo province, four areas were chosen:

Polokwane: Various areas were visited in Polokwane, the head office of Limpopo province. This is the only urban centre covered in Limpopo. This was an obvious choice because other urban centres in the province are very small.

Ellisras: Since Polokwane is located in the central part of province, it was decided to choose areas in the west, south, east and north of the province. Ellisras and neighbouring areas are located in Waterberg region (western Limpopo) near Botswana-South Africa border. Seven areas were visited and they were all rural. These are Chrome Park, Moshate, Lekalakala, Ga-Molekane, Ga-Ditshoene and Sekgakgapeng.

Venda: The choice of Venda was based on the fact that the language spoken (Tshivenda) is different to the one (Sepedi) spoken in other parts of the province. In addition, Venda was one of the independent states during apartheid, which means people were subjected to different circumstances in their families. The visit to Venda covered both the eastern and northern parts of the province. Two urban areas (Makhado and Tshandama) and six rural areas (Maungani, Itshani, Mbahe, Mbaleni, Tshituni tsa Ntha and Mushengoville) were visited.

Sekhukhune: Sekhukhune region is located in the southern part of the province. The areas visited were easily accessible in term of being a short distance from Polokwane and roads were tarred in most of the areas visited. The whole region is very rural. Places visited are Ga Marishane, Vlaakplaas, Ga Masemola, Ga Nkoana and Vecplaats.

Three locations were chosen in Eastern Cape:

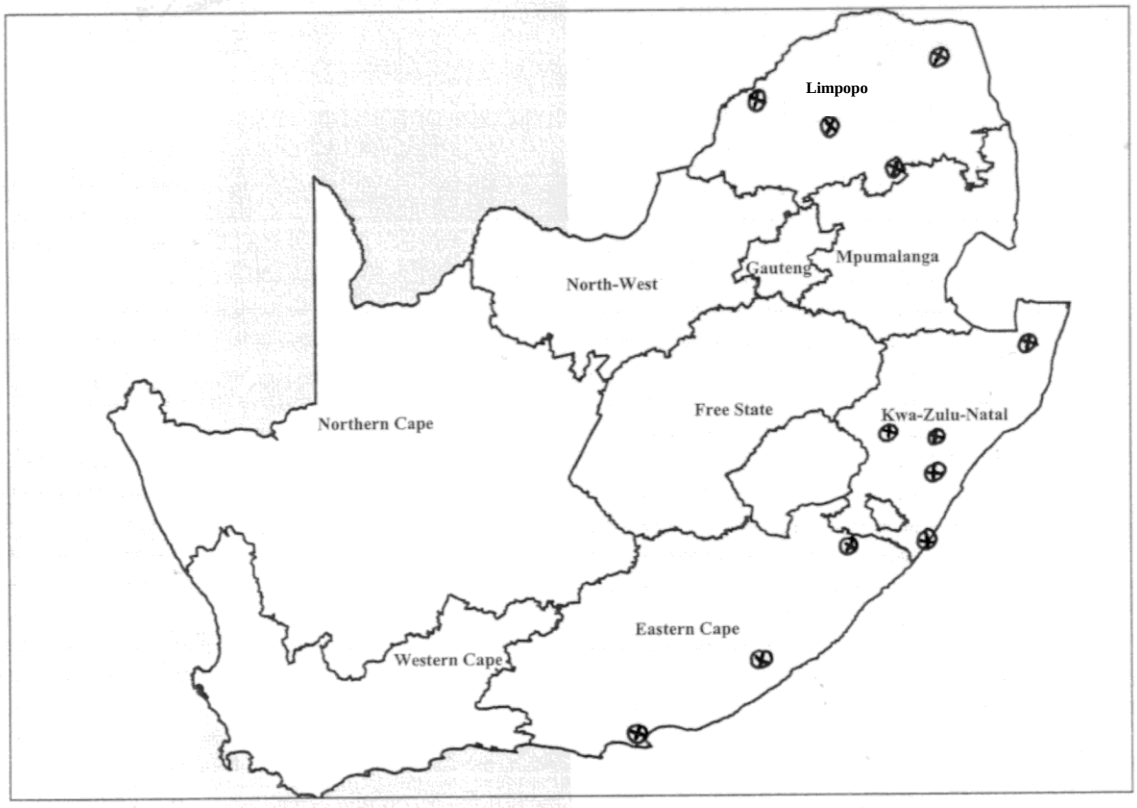
Areas surrounding Alice: Alice is a small town where the University of Fort Hare is located. Various rural areas around Alice were chosen including Ntselamanzi, Fort

Beaufort, Balfour, Dimbaza, Zwelitsha, Sweetwaters and Phakamisa. These villages were chosen due to their proximity to the University where the research team was located. In addition, they all belong to the former independent state of Ciskei.

Areas surrounding Kokstad: Kokstad is located in KwaZulu-Natal but the surrounding areas visited are in Eastern Cape. This means the areas visited were not too far from the border of the two provinces. All areas visited were rural (Mzimkhulu, Mt. Ayliff, Nkanji, Emsukeni, Dundee and Mpumanze). These areas belong to the former independent state of Transkei.

Areas surrounding Port Elizabeth: This is the only place in the Eastern Cape, chosen for the study, that used to belong to the former South Africa. In addition, it is the only urban setting chosen. Five locations were visited (Kouga, Kwazakhile, Uitenhage, Alexandria and Port Alfred).

Map 1: The Republic of South Africa



Note: Study areas are indicated by

2.4 Selection of Respondents

Permission to visit areas was obtained from the Chief of the area, locally known as *Inkosi*, *Kgosi*, etc. Usually the Chief was contacted by telephone or a visit was planned in advance by the fieldwork supervisor. The broad research questions were discussed with the Chief. Each area/village was visited for a day. In most cases it was the Chief who assisted in getting access to people. The focus group discussions were planned in advance. There was no single method used to select respondents. The main criterion was availability of people. This means that while in the area/village, people who were available were interviewed. The fieldwork supervisor's responsibility was to make sure that selection of respondents is done properly. For instance, to make sure that there was a balance of interviews with young and old people, men and women, etc.

The following instructions, which were followed very closely, were given to fieldworkers as part of their training.

How to identify participants for FGDs and IDIs

For in-depth interviews:

- Families will be approached from their residences. In order not to miss any families, it will be important to conduct interviews during the day as well as during weekends. This will ensure that we do not miss families whose members work during weekdays.
- While in some cases families and households will coincide, in some households there might be more than one family. It will be important to identify the various families and then ensure at all times that the members of the family being referred to are those of the family in question.

For focus group discussions:

- Members of families will be identified and arrange for convenient times. Those willing to meet for focus groups at suitably arranged times will be exempted from in-depth interviews.
- Small incentives for those who will accept to participate in focus groups will be given. These will help in attracting participants. However, it is important to ensure that these do not give the respondents ideas about what is expected from the focus group. No cash incentives shall be given to families.

2.5 Fieldwork Experience

Fieldwork was a success in all three provinces. In fact, the number of interviews conducted is more than what we anticipated. However, various problems were experienced during fieldwork. Most of the areas visited are rural. Consequently, families visited are very poor. A lot of people were therefore complaining about unemployment and poverty. Unfortunately, some people misunderstood our activities. They thought we could assist in solving their problems such as by providing employment.

We decided to provide an incentive for people who participated in the study. The incentive was different for different areas and for different respondents. For instance, soup powder was preferred among old women, a pack of 1kg of sugar was given to young people. The price of an incentive per person was between a half and one US Dollar. Measures were taken to avoid incentives which could influence the responses. First, an incentive was given at the end of interview and it is not mentioned at all until that time. Second, areas were visited for just a single day so as to avoid going to a place where people know in advance that we provide incentives. It should be noted that incentives were received very positively and we encourage researchers to entertain this habit. It makes a lot of difference to give a person 1 kg of sugar who does not know where his/her next meal will come from.

The most unpleasant experience was that which happened to the KwaZulu-Natal fieldwork team when they visited Port Shepstone. According to the fieldwork supervisor's report the "Port Shepstone trip was a disaster". The team arrived in Port Shepstone on 20 March 2003 and left on 22 March 2003 without being able to conduct a single interview. First, the contact person who agreed to assist by introducing the fieldwork team to the Chiefs changed her mind and could not be met on arrival. The team decided unsuccessfully to locate the Chiefs themselves. The weather (rain), bad state of the road (slippery), and bad state of the vehicle did not help the situation. For instance, the vehicle had a puncture twice when it was raining and the road was very slippery which made the team spend a lot of time on the road. The team was instructed to go back to Durban on the third day.

Other problems were minor. In Jozini (the first place visited), the fieldwork team did not have enough experience especially when it comes to organizing focus groups. That is the reason for not having enough FGDs in Jozini and the neighbouring areas. In addition, we had to revise the interview guide to include questions that cover issues that were not anticipated. For example, we came across 'scattered' families and there were no specific questions to assist in collecting information from these families. In Waterberg region (Ellisras and surrounding areas), people were not cooperative. They were complaining that many studies have been conducted in their area/villages but there is no feedback mechanism in place. The same notion of not getting feedback was repeated in Sekhukhune, but it was raised in a pleasant manner. It is advised therefore the study should design mechanisms which will help people know what is going on.

2.6 Data Processing

In each interview conducted, whether it is an in-depth interview or a focus group, background information of respondent(s) was collected using the form attached to the interview guide (see Appendix A3). The first step in processing rapid assessment data was to capture the background information in the Statistical Package for Social Scientists (SPSS) software. These data were analysed and are presented in Chapter

3. The summary of the number of interviews done in each area is presented in Table 1. A total of 403 interviews were conducted in the three provinces: 172 in KwaZulu-Natal, 142 in Limpopo and 89 in Eastern Cape. It should be noted that the combination of focus groups and in-depth interviews conducted in each province is different.

The second step involves transcribing the information recorded in cassettes using tape recorder and write it on paper. This step created transcripts in local languages. The next step was to translate transcripts into English. People who translated transcripts were fluent in both English and the local language that was translated. These were usually post-graduate students. The fourth step was typing. All created transcripts were typed and saved as plain text. Two professional typists were recruited for this purpose.

Table 1: Distribution of interviews conducted during the rapid assessment

	FGD	IDI	TOTAL
KwaZulu-Natal	**16**	**156**	**172**
Jozini	06	24	30
Estcourt	04	42	46
Greytown	01	57	58
Port Shepstone	00	00	00
Pietermarizburg	05	33	38
Limpopo	**53**	**89**	**142**
Venda	16	17	33
Polokwane	14	33	47
Sekhukhune	15	23	38
Ellisras	08	16	24
Eastern Cape	**51**	**38**	**89**
Alice	16	10	26
Kokstad	19	09	28
Port Elizabeth	16	19	35
TOTAL	**120**	**283**	**403**

A workshop was organized in May 2003 in Durban to read the transcripts that were completed (approximately half of them). Participants of the workshop included the principal investigators, collaborators, other experienced researchers, and a representative from UNFPA Country Office in Pretoria. Also, various junior researchers were invited for capacity building purposes. Strategies for analysis were discussed in details during the workshop. Eight themes were identified along with sub-themes. Transcripts were then read using QSR N6 software and coding was done using the eight themes as nodes. The codes created are the ones analysed and the results are presented in the analytical chapters 4 to 11. Before presenting

the results, we first discuss the characteristics of respondents who were interviewed in this study.

CHAPTER THREE

CHARACTERISTICS OF THE SAMPLE

The total number of respondents in this study is 1,096. The breakdown of respondents by the three provinces is as follows: 24.5% of respondents were interviewed in KwaZulu-Natal; 41.5% in Limpopo and 34.0% in Eastern Cape. Overall, there are more interviews conducted in KwaZulu-Natal (172), but the number of respondents is much smaller than other provinces. This is because there were fewer focus groups conducted (20) compared to in-depth interviews (155). In all provinces, there were more females than males interviewed (see Table 2).

Table 2: The number of respondents in each province

(A) INDEPTH INTERVIEWS

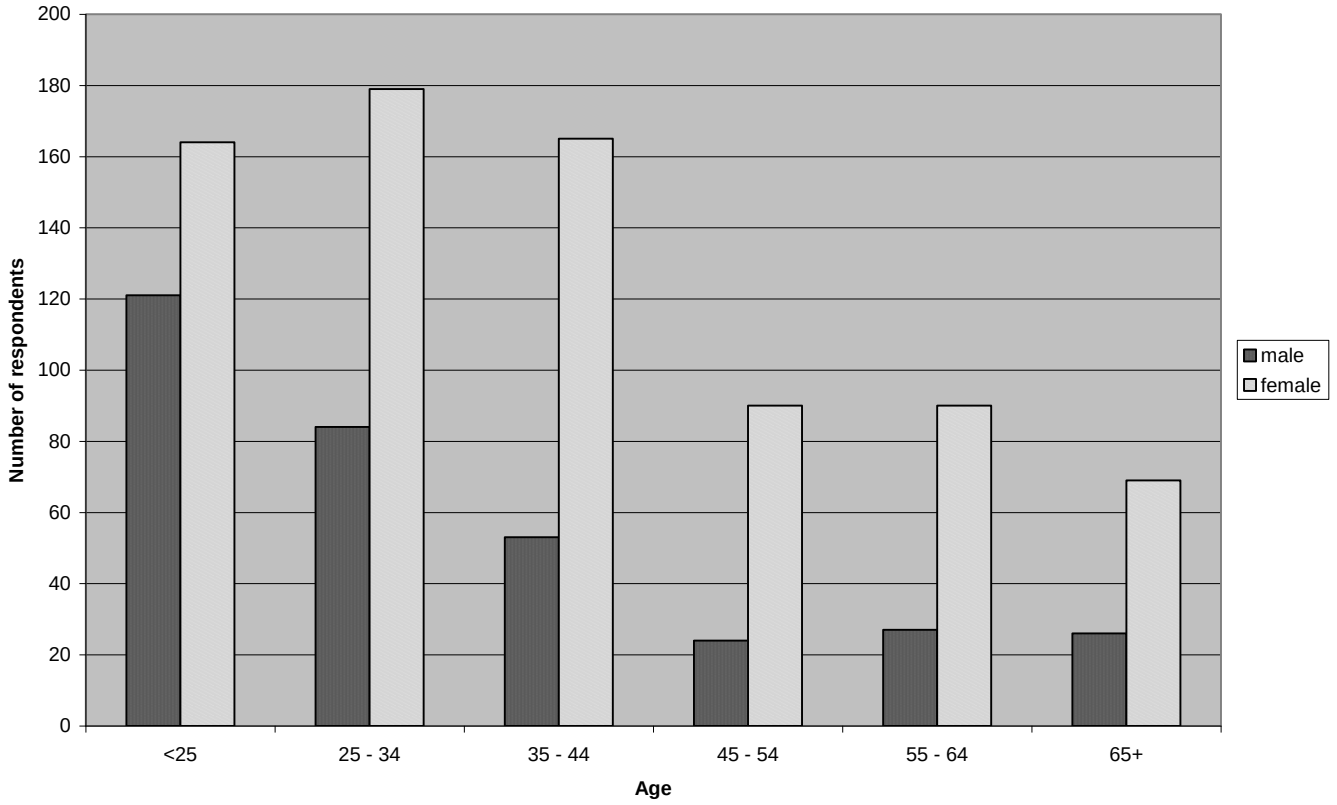
PROVINCE	MALE	FEMALE	TOTAL
KwaZulu-Natal	35	120	155
Limpopo	41	48	89
Eastern Cape	13	25	38
TOTAL	89	193	282

(B) FOCUS GROUPS

PROVINCE	MALE	FEMALE	TOTAL
KwaZulu-Natal	37	76	113
Limpopo	141	225	366
Eastern Cape	68	267	335
TOTAL	246	568	814

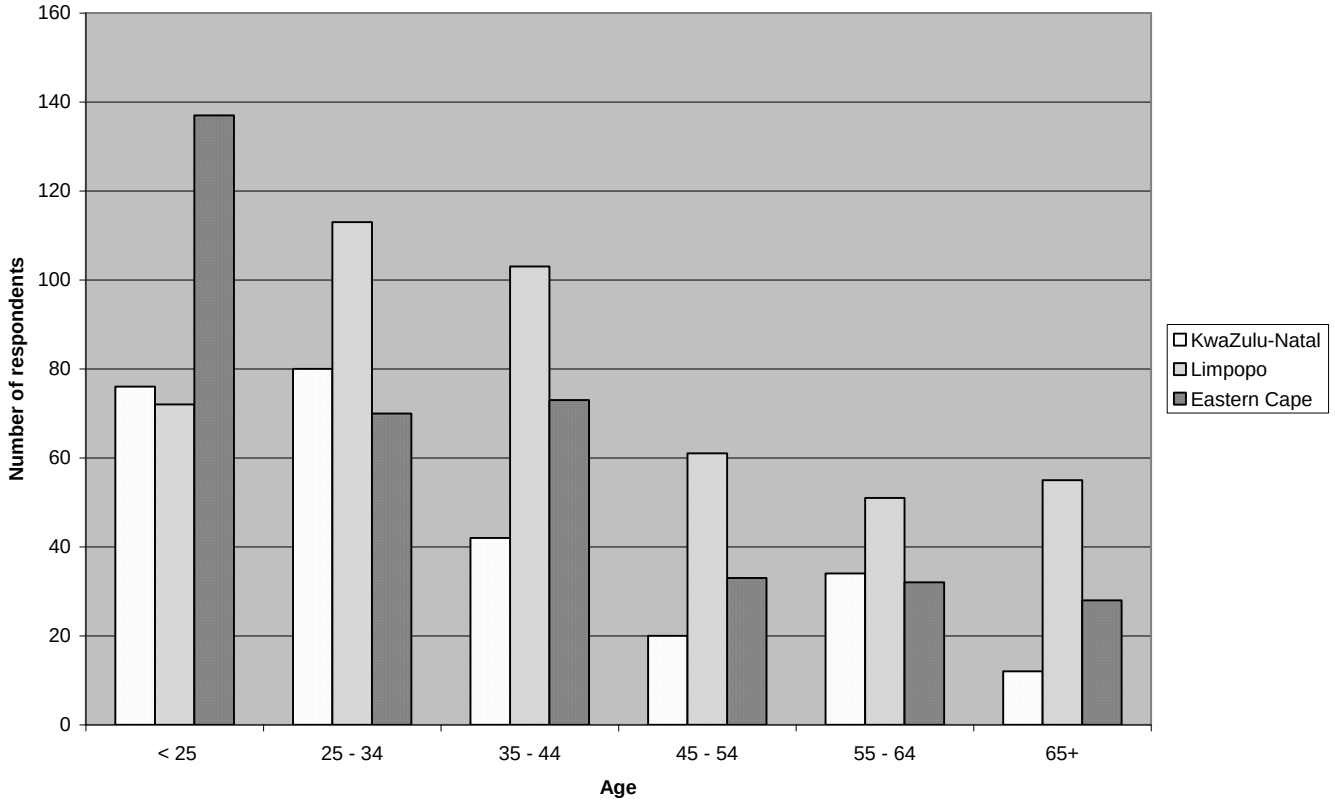
Figure 2 presents the breakdown of the number of respondents by age and sex. As indicated earlier, female respondents dominate in all age groups. Only one-third of the sample are males. The distribution of respondents shows that selection of people in the sample was not very biased. There were people as young as 12 years old and as old as 90 years old.

Figure 2: Number of respondents by age and sex



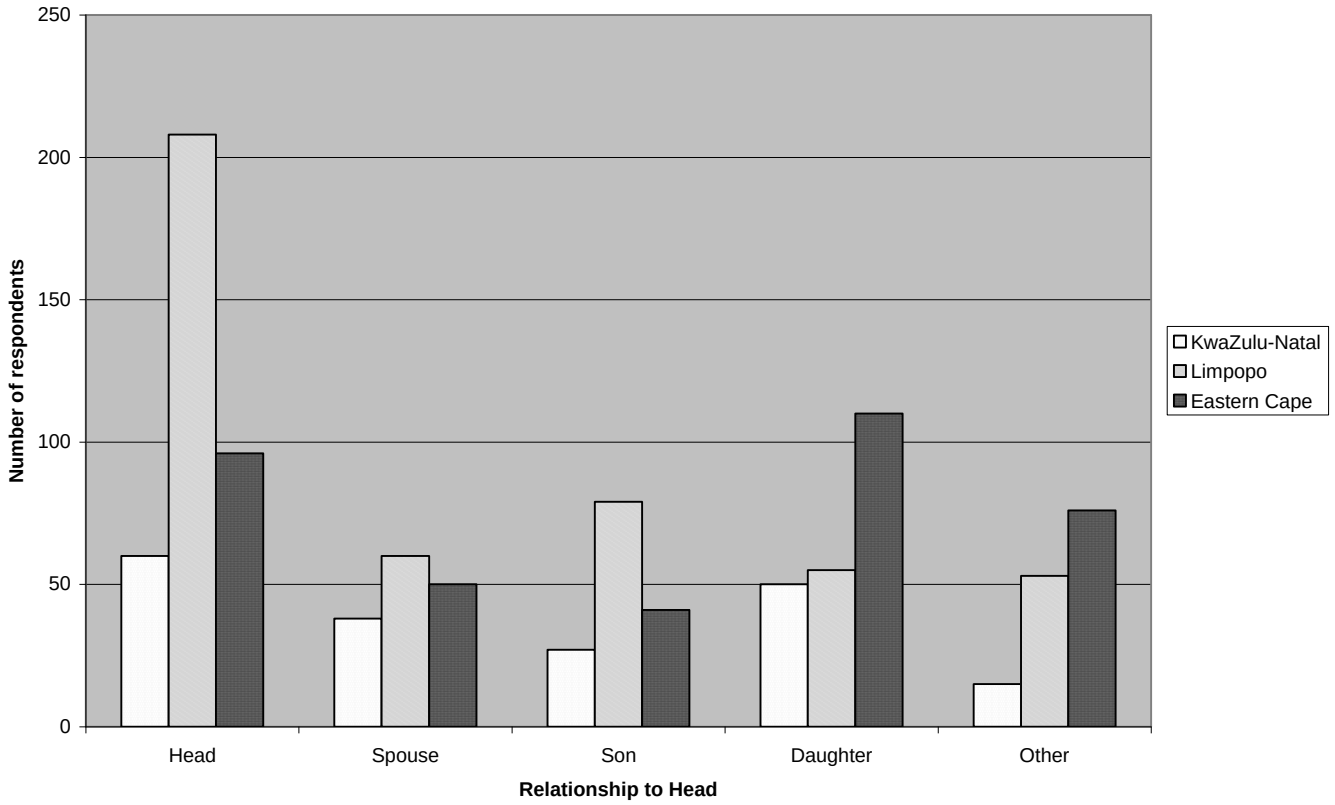
The number of respondents by age for each province is presented in Figure 3. It can be observed from the figure that there is a fair representation of people in various age groups. In other words, people of different age groups are included in the sample in each province. Obviously there are minor discrepancies such as young people being over represented in Eastern Cape or middle aged people being more than both young and old in Limpopo. But these discrepancies are not likely to affect the findings.

Figure 3: Number of respondents by province and age



The sample of the Limpopo province includes a lot of household heads. Otherwise the distribution of respondents according to the relationship to the head of the household is even (Figure 4). If the respondent is not the head of household, s/he will be a spouse of the head or a child of the head. The 'other' category includes any other relative of the head such as a sibling, parent, grandchild, etc.

Figure 4: Number of respondents by province and relationship to head



The majority of respondents are either currently married or single (never married). The number of widowed respondents especially among females is significant (see Figure 5). As far as highest educational level attained is concerned, most of the respondents have attained standard 1 to 10. A substantial number of respondents in Limpopo have attained just grade 2. Judging from Figure 6, it can be stated that very few respondents do not have experience of going to school.

Figure 5: Number of respondents by sex and marital status

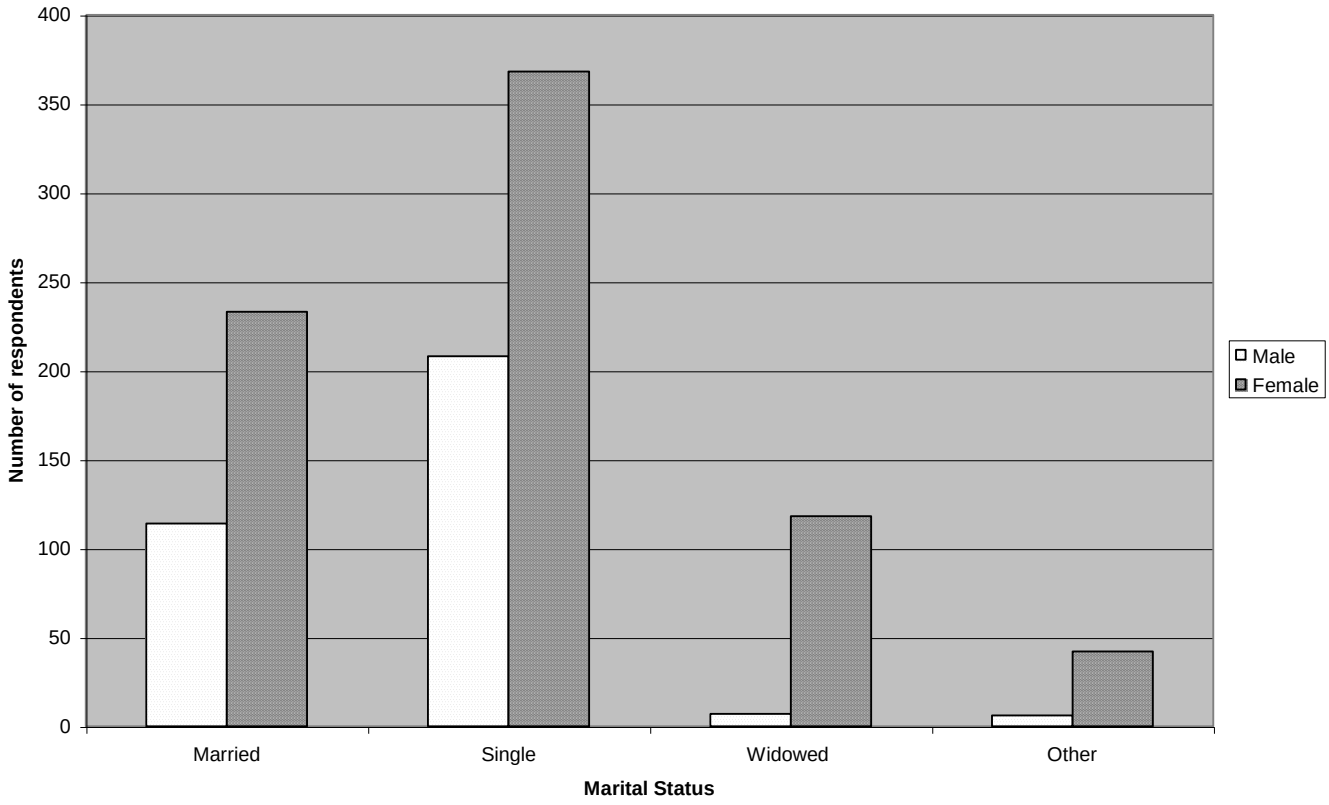
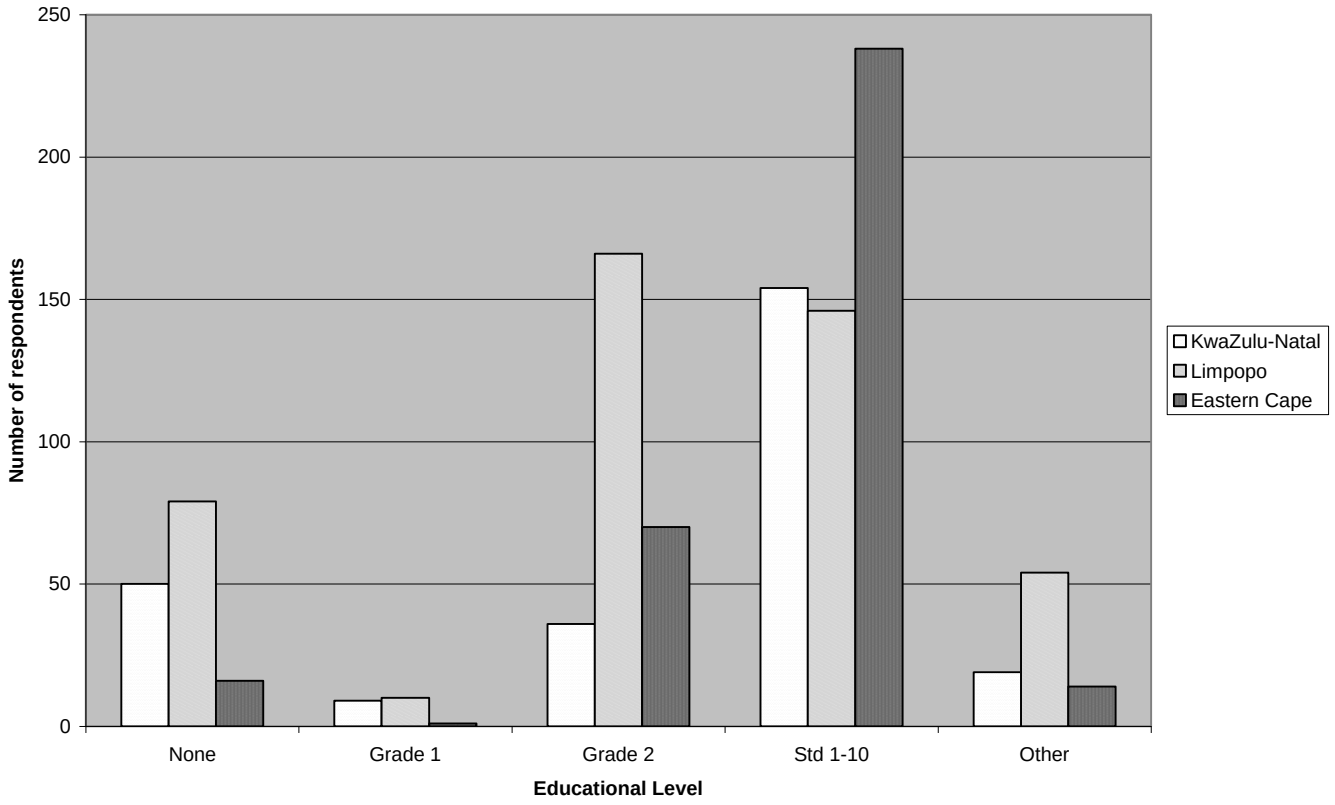


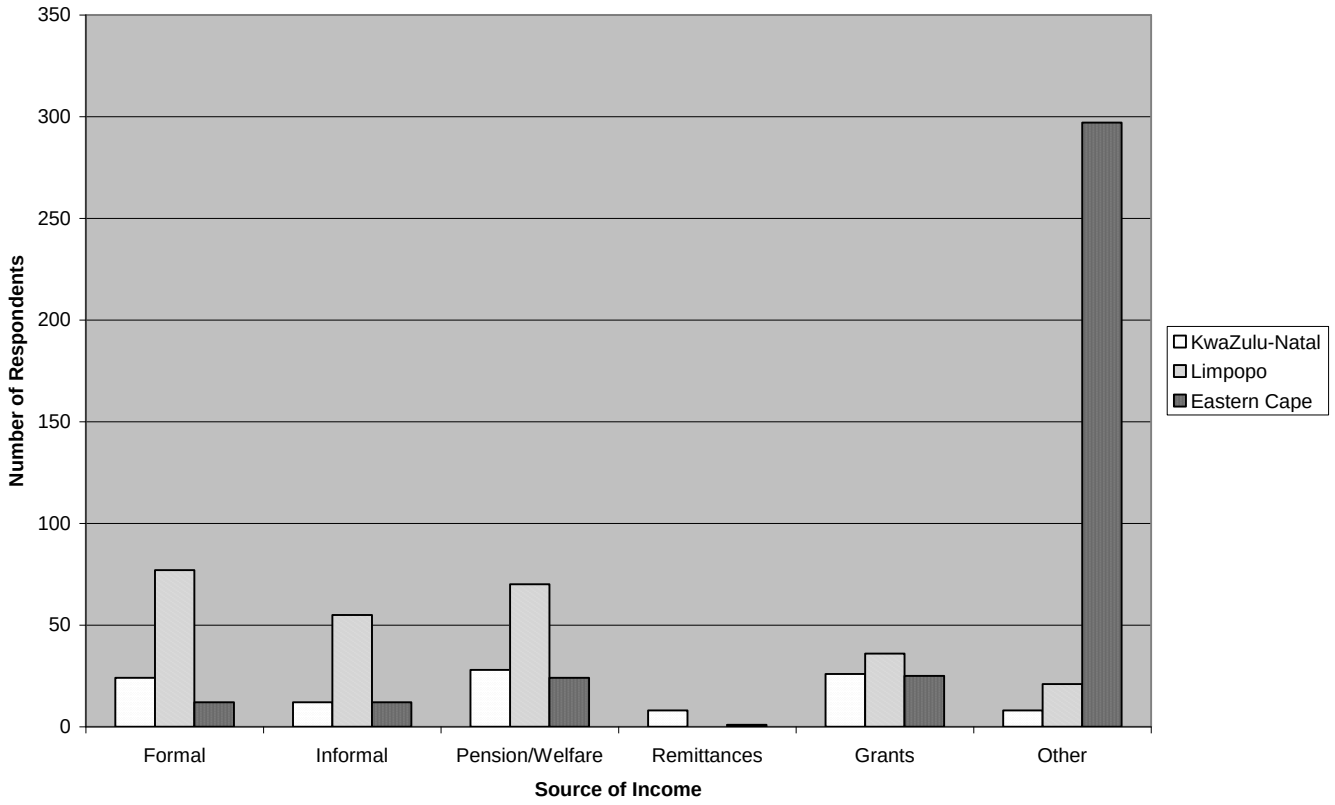
Figure 6: Number of respondents by province and highest educational level



During the fieldwork, information on the monthly income and the main source of that income was collected. The income data show that household income was as low as R40 and as high as R5,500. Half of the respondents who reported their income were receiving less than R60 a month. Using a recent poverty line of R900 suggested by Mturi, May and Hunter (2003), 83% of the respondents are poor. Respondents interviewed in KwaZulu-Natal and Limpopo reported the source of their income to be both formal and informal earnings as well as pension/welfare and grants (see Figure 7). The majority of respondents in the Eastern Cape did not specify the source of their income.

The characteristics presented in this chapter indicate that there is no serious bias of respondents who took part in the rapid assessment. The sample consists of poor people who are not well educated and were interviewed in selected key areas of the provinces. They can therefore portray a rough picture of the circumstances families face in these three provinces.

Figure 7: Number of respondents by province and source of income



CHAPTER FOUR

FAMILIES AND FAMILY STRUCTURES

4.1 Introduction

In recent times, South Africa has undergone social and political transformation, which has had implications regarding changes in the structure and composition of the family. Differences in the understanding on the definition of a family versus a household and homestead have been documented in social science literature (Buddlender, 1997; Hosegood and Timaeus, 2001). Some of these definitions complement each other in some way. Problems also occur when dealing with several languages that sometimes do not differentiate clearly between these terms. Often the reason research focuses on the household is purely practical but since this study focuses on the family, one of the key factors is to understand the way in which different people define a family.

One of the topics discussed during interviews was the issue relating to the changing structure and composition of families. Discussions were held during both in-depth interviews as well as focus group discussions with males and females. Issues under discussion include definition of the family, types of families, the concept of who the heads of the family/household are and how they come to be considered heads as well as any intergenerational conflicts identified. Participants provided responses according to their views and practices and what they perceive to be happening in other families within their communities.

4.2 Definition of the Family

The definition of the word or concept family/household was given different form by different people. In Tshivenda language, for example, there is no word that defines separately household and family. The word *Muta* means family. There is no word for household. The concept family refers to a social network living together or not currently living together while maintaining social relations. Muncie *et al.* (1995: 10)

define a family as “a small unit derived from a relationship between a man and a woman bound together through marriage as husband and wife”. On the other hand, household refers to people living together at a particular place at a particular time who may not be essentially related. It is a “special category where a group of people are bound to a particular place” (Muncie *et al.* 1995:11). In an African setting, families are not expected to be small and the relations permeate beyond husband and wife to include distant relatives and even the dead as members of the family.

The most common definition of the family across the study areas was the primary definition of the nuclear family. According to the majority of respondents family refers to a married couple who stay together with their children. These respondents stressed the fact that the couple should be married to be considered a family. In addition there were strong views raised that in the family the man and the woman should have good relations and have a responsibility towards raising children together with respect. The following are typical definitions given by participants during the interviews.

When we say a family, we mean a man and a woman and children. A family is something that is formed by two people, a man and a woman, between them there must be respect if not then it won’t be a good family. A woman must get respect from children; a man and woman must have responsibility. I understand that a family comes in the form of marriage. If you are not married then it is not a family. There won’t be control and discipline; you will find a person saying you are not married now and then.

IDI, young female, rural Limpopo

The word family refers to a husband and wife blessed with marriage, either having children or with no children as long as their marriage is blessed that is a family, one respondent remarked. While the other explained, According to me a family is cooperation between a man and woman. It is a true friendship when a man and woman are married; if they are not married then it is not a family.

FGD, young males, urban Limpopo

We are referring to a man, woman and children in general. A woman and a man build the family, they must have responsibility. Responsibility is the accountability that a man should have toward his wife and the woman should also be accountable towards a man by having children.

FGD, elderly males, urban Limpopo

A family is formed through marriage of two people, a woman and man. Then they get children and form a family.

FGD, females, semi-rural KwaZulu-Natal

I believe a family is between married people who have children. I can say that it is something that is constructed, like say I can point to a household and say it belongs to so and so.

FGD, young females, rural KwaZulu-Natal

Family consists of married couple and children living together.

IDI, female, urban KwaZulu-Natal

The above statements can be supported by literature from previous studies. Glick (1957) defined the family as the basic social group that is united through kinship or marriage bonds. He considered the family to start from marriage and then followed by the bearing of children. Thus the family provides affection and emotional support particularly to infants and young children. While according to Preston-Whyte (1978) "the concept of a family carries with it notions of kinship, continuity and also suggests emotional involvement as well as long-term commitment".

During interviews some respondents mentioned that even if those two people are not married or they do not have children but stay together they were still considered to be a family. Marriage was not mentioned to be core issue when it comes to having a family and raising children mainly because they reported that nowadays women are expensive and most men are unemployed so they cannot afford to marry. The following reflects some of the opinions.

A family is when a man and a woman are living together, they have children and they support each other during the good and the bad.

IDI, adult male, rural Limpopo

A family is a responsibility and decision of a man and woman to stay together with children. So when there are problems in the family they are resolved by the woman and the husband.

FGD, adult females, rural Limpopo

A family is a home for two people being a man and a woman when they just got married. They prepare a future for the children. But today we don't have a lot of marriages because these days men no longer marry and the reason is because they do not work. There's no money for marrying whereas these days women are expensive. In our culture you can't live with a woman when you can't marry her. Marriage actually is communion by our ancestors. A woman is introduced to women and a man introduced to men. It's not possible for a woman to join women outside marriage.

IDI, adult male, rural Limpopo

Family is when mother, father and their children live together in a household.

IDI, female, urban KwaZulu-Natal

A family is composed of the mother, father and children**.**

FGD, females, semi-urban KwaZulu-Natal

It is the mother and father and then find children. Then, that is called a family.

IDI, female, semi-urban KwaZulu-Natal

A study by Hosegood and Timaeus (2001) noted that “in most parts of Africa, individuals usually live in domestic groups that have shared characteristics ranging from financial resources they can draw upon, through the authority they acknowledge for decision-making, to the reciprocal influence of members on each other’s behaviour”. In general terms, the family is considered to consist of the father and the mother living together with their dependent children. So it might not be surprising to find people forming families and living together out of marriage.

A very strong deviation from the above mentioned definitions were noted in KwaZulu-Natal. There, a family was more viewed as a big group of people linked together by lineage. This came up very strongly when most respondents would mention that a family is formed by all individuals belonging to a particular name. Culturally this is how the Zulu nation views a family. In this way, KwaZulu-Natal would be seen as viewing the family in an extended manner, i.e. including all patrilineal relatives.

A family refers to people of a lineage. It is people who are united. It is people who help each other if there is a need for that.

IDI, female, semi-urban KwaZulu-Natal

I would say a family is people who are united like me at this home I am a grandmother. There are sons, daughters and grandchildren. We are people who were born from one 'house'.

IDI, female, rural KwaZulu-Natal

I would say I arrived at this home and got married. When I got married here, I got children and they were called a family of Mxolisi (not real name) together with the children's father who was born by the father-in-law and mother-in-law. Together, we are called Mxolisi family.

IDI, female, rural KwaZulu-Natal

The study also indicates that there were participants who defined a family as a place where people stay. These respondents defined a family in terms of the physical structure. It might have had something to do with the way they understood the word “family” in their local language. For instance in Sepedi there are two terms used,

namely *lelapa* or *legae*, which might either refer to members of the family or to the physical structure of the home.

Family is a home where we stay. Each and everyone come home, must sit down and we eat at the same time and same place, said one respondent. Is a home where a man and woman stay, then they start to have children, explained the other.

IDI, female, rural Limpopo

Other various definitions of family were also given. Some respondents argued that there should be a mandate granted by the in-laws for a couple to be regarded a family. It can be inferred that such authenticity is derived through the payment of *lobola*. Although this cultural practice has declined due to modernization, payment of *lobola* remains unassailable as a source of legitimacy.

It also emerged in the research that even if one of the spouse or one spouse pass away and the family remains. Respondents expressed it as follows:

Even if your husband passes away he is still a family.

IDI, elderly female, rural Limpopo

Another one is where the mother looks after children when the father has passed away.

IDI, female, urban KwaZulu-Natal

A family is a group of people who live together and create a home. The types of families that are in this area are families where women live alone with children because the father is dead.

IDI, male, rural Eastern Cape

In addition to the above, some of the respondents highlighted that the family must be supportive for it to remain close knit. In a focus group discussion conducted at Maungani, one of the rural areas in Venda one woman responded that,

A family is a husband and wife who support their family. If you do not have a husband you will be the one supporting it alone.

FGD, females, rural Limpopo

And a man said,

Family can be people living together in a household. Also relatives ensuring that the needs of the households are met. Also when there are referred to as family. A number of people living in similar or one household having no major problems.

IDI, male, semi-urban KwaZulu-Natal

It also became apparent in the research that the institution of the family was created a long time ago and it still exists. This shows that people are born into families. They grow in families and when they reach maturity they in turn form their own families.

It was created long time ago. When we grew up it was there and we became old then we had our family.

IDI, elderly female, rural Limpopo

As shown in the above quotation, it shows that a family is a web of relationships. The multiplication of families give a much a bigger family and ultimately a society. In an in-depth interview with one of the chiefs in a rural area, a Chief expressed this sentiment as:

I think is a family is unity between a man and a wife who work together within families in a society and also support each other, love and face the world together.

IDI, female, rural Limpopo

And a woman said,

A family refers to people of one lineage. As you have said, members of lineage splits up and build their household in different places but still remain united people of one family.

IDI, elderly female, semi-urban KwaZulu-Natal

4.3 Types of Families

During the interviews participants discussed different types of families that exist in their communities. The question posed to participants read thus, “What kind of families do you have in your community?” Different types of families were mentioned by respondents, which included nuclear families, extended families, single parent families, skip-generation families as well as child-headed families. According to the respondents there appears to be an increase in the number of skip-generation families and child-headed families as well as single-parent families. There were various reasons mentioned that lead to the existence of such families.

UNFPA (1958) reported that different types of families that rival the nuclear/biological family growing in prevalence. There are extended families, which consist of more than

two generations of a biological family. These types of families are found in societies where it is not the custom for children to leave their parental home on marriage, particularly the African population in South Africa. In addition these families arise as a result of children leaving their biological family to join another for various reasons. According Sadasivam (2000) with all the changes taking place, it means that traditional families are undergoing changes with new formations emerging such as reorganized families, consensual unions and single-parent households.

During interviews the majority of respondents mentioned that there were many families where children are left alone because parents have passed away or they have moved to other places to look for jobs and as a result the elder children have to take care of their siblings. Only a few indicated that some such families get support from their relatives but the majority of them struggle on their own to survive. The fact that most such children have no adult member in the family to take care of them reflects the extent of the weakening role of the extended family within communities. In the past it used to be a norm that when children are orphaned, at least some members of the relatives decide to be responsible for those children. So it was also indicated during the interviews that according to the Sepedi culture, for example, when the parents of children have passed away then the relatives meet and discuss. Thereafter they decide on who will take care of those children. However, this is no longer happening in that most relatives are now distancing themselves from that responsibility.

Child-headed families arise out of, among other things, migration, where parents migrate to cities to look for work. Another reason is death of the parents, and in rare cases children not wanting to join or live with other relatives in the absence of parents. In many of the discussions, it was found that, more often than not, network ties exist to support this type of family. It is likely that there will be aunts, uncles and other forms of family networks supporting such families. This could however not be generalized because, as stated above, in some places relatives avoid such responsibility.

Our neighbour at the back, the children lost their mother and were left with their father, but last week we buried the father, so children are left alone.

IDI, female, rural Eastern Cape

Or were not able to help adequately,

Lawfully the government must help us. For example, there are my brother's children whose father passed away and their mother followed him immediately. They are living alone. We go to check them but we do not have the ability to help them. We also do not have people who help us.

IDI, elderly female, rural KwaZulu-Natal

Extreme poverty creates conditions in which all adults in the family must work outside the home. Thus, alternative care is sought within the family and siblings are called upon to provide care, studies show that the factor most affecting whether a family escapes from, or returns to, a condition of extreme poverty is employment of family members. Securing employment may help the family earn more income to survive, but also creates these categories of child-headed household in the process.

In this type of family arrangement, the parents usually have migrated to cities in search of jobs but are still in contact with the family. Those families rely a lot on social networks such as neighbours and other relatives. The children have links to the parents and sometimes go to cities to visit their parents. Although the parent will rarely visit home, in many instances, these type of families get a great deal of support from grandparents although they might not be staying with them.

Some families have children staying alone because their parents passed away. In other words, these are families of orphans. While many of these families will have social networks and support, some do not. A case in point is a family of six young orphans in the Eastern Cape who have no one employed in the home as they are all young and do not have relatives that the group know of in the vicinity. Other examples are given below.

Yes, there are children who head families, they are orphans. They don't have a father, mother or grandmother, they stay alone.

FGD, adult females, urban Limpopo

Although I do not know about this area, but there are such families in areas where I come from. There are families that have neither father nor mother. Children are living by themselves. I came up here to join the big family after my family members passed away.

IDI, elderly female, semi-urban KwaZulu-Natal

There are families that have no parents. Children stay by themselves and try to do some little things and then call themselves a family. **FGD, males, rural KwaZulu-Natal**

Yes, so far I know many families. There are many which parents have passed away and they grow up under the responsibility of their brothers who are breadwinners in the family. So according to me such families have problems because they miss their parents too much and they do not become open to the person who is responsible and taking care of them. **IDI, male, urban Limpopo**

Another not very common category is orphaned children who stay alone and prefer not to join relatives. Below is a case in point.

I stay alone…my parents passed away…I do have an uncle in Quzini but they treat me badly together with his wife.

IDI, male, rural Eastern Cape

Or for some reason don't stay with relatives,

There is a family of my sister that has daughters who have children. . the father and the mother passed away. Children live alone.

IDI, female, rural KwaZulu-Natal

In some cases there appears to be nobody the children can live with,

My father passed away in 1995 and my mother in 1998, they were not too old but they were sick…my elder brother is now taking care of us, but he doesn't stay here with us.

IDI, female, rural Eastern Cape

The major trait of families consisting only of children is that they are in dire poverty as the following extract illustrates,

It is just I am far from it but I can see that it is not good anymore because the elder child was 14 years when left by the parents and now the household is collapsing . The situation is not good at all.

IDI, female, rural KwaZulu-Natal

It was evident that in some instances, these kinds of families would later move to join relatives, as they have no capacity to sustain themselves. The case presented below had to find other support in very extreme situations.

They have been living there for sometime, but when the house fell, leaking became excessive due to poor maintenance; those children were forced to live with their relatives when the house ultimately collapsed.

IDI, female, rural Eastern Cape

There is only one family I know where there are children only. But Inkosi took them to the welfare. They had no parents, both had died. They were very poor.

IDI, female, semi-urban KwaZulu-Natal

Skip-generation families were reported both in rural and urban areas. One of the significant reasons mentioned for this type of family was that parents of children either die or move to other places for one reason or the other and therefore, grandparents have to take responsibility of their grandchildren. It is a common practice in most of the areas of South Africa that children are left with grandparents especially when parents work far from home. In other cases mothers might get married to another man and decide not to take the children along to the new home hence they are left behind with their grandparents.

Sometimes the children are left by their parents because their mothers or fathers are working. The grandmothers are living well because they earn pension and I think their pension is able to support them because it is bigger than the child support grant.

IDI, female, rural KwaZulu-Natal

There are families that have no one, families that have grandmothers that live with their grandchildren only. Sometimes the mother of a child passes away and the child would be left with his or her grandmother. Sometimes the mother of the children gave birth before marriage. In other cases, the mother found a child but does not know the father and passes away. The child will then be left with the grandmother.

FGD, males, rural KwaZulu-Natal

It is caused by children who give birth out of wedlock and leave those children when they marry at another place, other than were she found her child Then, the children end up being left with the grandmother as they are diseases others give birth and die and then leave these children.

IDI, elderly female, rural KwaZulu-Natal

Single parent families were also reported especially those headed by females. Respondents reported that there are no marriages these days and so most women

end up raising children on their own. Some male respondents mentioned that marrying a woman is expensive and most men are unemployed so they do not have money to pay *lobola*. It appears that most women do not raise their children alone out of choice but mainly due to the non-existence of marriage. This situation is also created by divorces or separations in the families. Such situations were reported in both rural and urban areas. The following excerpt gives a picture of what respondents had to say.

I pity those families without men, most women failed to be married. They built their own houses and they are finding it hard with children, remarked one lady. The other one explained, families are there but there are no men. Most of the women used to have men but unfortunately their men left them, they left them poor and those women do not get old age pension money.

FGD, adult females, rural Limpopo

In many instances a range of family structure were reported,

In some families there are no parents, some families have parents, others are grandparent headed families living with their grandchildren.

IDI, young female, urban Limpopo

There are child-headed families in our area. There are different reasons; sometimes the parents left to seek work and sometimes the parents have passed away. Grandparent headed households are caused by the passing away of parents or some parents who have left their family and they are nowhere to be found.

FGD, young females, rural Limpopo

Some families have men, some are orphan families and some are headed by women.

IDI, adult female, rural Limpopo

Families differ others are women staying alone with children without a man while others have men and women in the family. Those children who stay alone we call them orphans. When they are alone in the family the head will be eldest child, the one born before all of them. That eldest child will have to take care of the other children and s/he will be the head.

IDI, adult female, urban Limpopo

Some previous studies complement some of the responses given during interviews. Mturi and Nzimande (2003) have reported that various studies have shown that the HIV/AIDS epidemic has played a key role in changing the family composition and structure in South Africa. The epidemic in combination with the breakdown of the institution of marriage is creating types of families that were not common in the past. Basically it has contributed steadily to a rising number of orphans because the majorities of people who are dying are in their reproductive years and are often parents who leave children behind (UNAIDS/UNICEF, 1999). As a result some

children have to look after their siblings by creating a new type of family called child-headed family. According to Shaw (2003) it is difficult to ascertain statistics for child-headed households in South Africa. However, Shaw cites a survey conducted by Statistics South Africa in 1996 which identified 95 963 child-headed households in the country.

4.4 Headship

The influence of traditional background was more pronounced in the aspect of headship than in other aspects of the family structure. Sex-roles and stereotypes, the increased feminization of the labour force, and decision-making responsibilities were the major issues that were raised around the headship debate. From the focus group discussions, it came out strongly that headship in the study areas is constructed along sex roles and decision making responsibility. It also emerged that autocracy in decision-making, that is, decisions having to be made by one spouse in many instances highlighted the dominance of the male as the head of the family. Other factors that were debated as determinants of headship were resource allocation, socio-economic status and experience. The other view that decision-making is a joint exercise between male and female was also debated and a few sympathized with the notion. Choosing a head also depends on how close one is to the parents, both mother and father, and how much each parent contributes in the family.

Participants in this study were asked to state the head of the family and why they consider that person to be the head. The question that was asked reads, “Who is the head of the family?” and the follow-up question was, “What is the reason?” There was a range of different responses that were given by respondents with regard to this particular question. The majority of the respondents mentioned that the head of the family is a man and for most of them the main reason for this was attributed to cultural norms. They indicated that according to the culture, a man is supposed to head a family and various reasons were given one of them being that since the time of their forefathers, the man was considered the head so they still carry that notion with them.

Both males and females across both rural and urban areas gave the same response. Others reasoned that the man is considered head because men are the ones who usually work and bring money in the family and they also lay down the rules. The following give a picture of some of the views.

Originally and according to our culture a man is the head of the family and he must maintain law and order in the family.

IDI, young female, rural Limpopo

A man is the head of the family, everything gets reported to him. When a man marries a woman it's like he says you will be my follower and she must look after the family when the man goes out to look for work, remarked one male. The other one said, a man is the head since when we were still growing up, we always knew that our fathers are heads. These days we are amazed by the new rules that we must listen to women.

FGD, elderly males, rural Limpopo

Head of the family is a man. Everything that my father says, we must all follow it. It is the man because he gives us rules and buys food because he works.

IDI, female, urban Limpopo

The head is the father and it is non-negotiable…
In the Xhosa custom, fathers are the head of the house.
According to the Xhosa norm the head of the home is the man.

FGD, males, rural Eastern Cape

I think it is an old-established custom because even in a magistrate court, when a mother comes for a will after the father's death they need a male to come forward and one realizes that there is no place for a woman.

IDI, female, rural Eastern Cape

To me, no matter who works and who doesn't, the head will always remain the father.

IDI, male, rural Eastern Cape

The head of the home is a father, but when he is not around it would be a mother who is the head of the home, like now, I have taken the place of the father of these children of mine here. I'm the father, I'm everything.

FGD, females, rural Eastern Cape

It is the father. Things were like that when we were born and when you were intimidated at home you were intimidated with the father.

FGD, females, rural KwaZulu-Natal

Other reasons for selection of men have to do with family formation. It follows that since the man is the one that asks the woman to marry him, and brings her to his home (and thus adopting his name), that he is the one whose decision forms the basis of the family. Due to this, he is the head of that family:

The head of the family is a man because he is the founder of this home. He brought the mother here to marry.

IDI, male, rural KwaZulu-Natal

It is father because he is the owner of the home. If there are problems, they are reported to the father.

FGD, females, rural KwaZulu-Natal

There are even reasons associated with religion. That God created men to be heads of households. These are followed by how roles assigned to men in the household cannot be replaced by women. In almost all cultural African settings in South Africa, men are the ones who carry out the rituals that connect the family with the ancestors. Men would be the ones who will slaughter the animal that will communicate with the elders. This is not to say women do not perform such roles, but there are boundaries that women cannot cross.

I would say God created the father to be the head at home. I cannot just do things for myself, such as slaughter a goat in the kraal when the father is alive. It is the father and father-in-law (who head the household). If we have a mother, we are still under the control of the father-in-law and father. If they have all pass away, my husband and I are left, which means I get under the control of their son (my husband). If their (father- and mother-in-law's) son also passes away, then I get in charge of the home.

IDI, young female, rural KwaZulu-Natal

I say it is the father even if he is not working. It is the father who is the head of the household. Even according to the bible, it is the father.

IDI, female, rural KwaZulu-Natal

The head of the household is a man because when we burn incense in the house, it is not a woman that speaks to the ancestors, it is a man. When the criminals break into the house, the woman wont do anything whereas I will use my big voice to scare them. I will say, who is that? And I will bit them and they will be surprised.

FGD, adult males, rural KwaZulu-Natal

Interestingly, some participants reported that both males and females could be heads of families because they are equal and they share responsibility in the home. Some males and females shared this opinion. There were those who mentioned that females could be head of families especially when the husband passed away and there is no adult male member in the family or the woman is not married and she is staying alone with her children. However, it appeared that female respondents in most cases were the ones who gave this response and for some men that woman is

only responsible for the children and cannot be called the head according to their believe. The following opinions reflect views from respondents.

According to me the head of the family is a man but people should also understand that the woman also needs to be respected. She has the responsibility in the family. The main reason is our culture, we found men being heads of family. If in a family there are children and mother, there is no head of the family. It is just that those are her children and she has to take care of them.

FGD, adult males, urban Limpopo

Mostly in our area heads of families differ. Both males and females are heads of the family. There is no longer that rule that says the head of the family is a male. In other families there are no men, there are only women.

IDI, adult female, urban Limpopo

According to me the head of the family depend on two people, they must negotiate and it depends on how the two live. When I grew up I found that the head of the family is the man but personally I think men and women are the heads of the family. **IDI, female, rural Limpopo**

In my understanding it balances, both males and females do head households.

IDI, male, urban KwaZulu-Natal

In some cases, participants indicated that the head of the family is or should be the mother or the wife.

The head of the family is a woman because she knows all the suffering of the family whether children are getting food or not.

FGD, young females, rural Limpopo

I say the head is a mother, because most homes are being taken care by them. When the mother dies, it is likely that the family will collapse, but if the father dies, it is not always possible for the family to collapse. So I can conclude by saying Yes, mothers deserve to be heads.

FGD, females, rural Eastern Cape

A woman is the one who knows exactly the pain and tribulation that children and people in general experience because many times men wander around but mothers sit down to think of their children, and at the same time she has to dish for the very man. The father sometimes goes to get something to drink but the mother chooses to share each R20 with the family.

FGD, females, rural Eastern Cape

I think it should be the mother. We mothers have a difficult task. We look after the children even if the father is present. If children want things , they want them from you. They do not say 'father'. Even food, too, they want it from the mother. Even school things are demanded from the mother.

IDI, female, rural KwaZulu-Natal

Female headed households because women take care of their children, they do not desert them. Men love women too much and forget their children. They can marry another woman who in turn will ill treat these children. A woman, if having an affair, will only do it for the best and benefit of their children.

IDI, female, urban KwaZulu-Natal

There were other cases where it was reported during the interviews that grandparents head families: the reason being that both parents in the family have passed away or they are unemployed so the responsibility of the whole family rests with grandparents. These are some of the comments:

There are many things that cause grandparents to be heads of families. These days you will find the mother and the father being unemployed. So the grandparents support the grandchildren because there are no jobs People stay at home and depend on the grandparents to support their children.

FGD, adult males, urban Limpopo

There are also grandparent families. They come about when both the father and mother die or when the father deserts and later the mother does the same.

IDI, male, rural KwaZulu-Natal

They are looking for job, can't find it and usually don't come back and live forever in town. By so doing we grandparents end up being heads of the family.

IDI, elderly females, semi-urban KwaZulu-Natal

Let me think, there is another type of family which is granny headed. She supports her grandchildren Either of her sons and daughters, nobody helps this granny and it is strange because granny has to be looked after, but in this case she is the one who looks after children.

IDI, female, rural Eastern Cape

For others, to be considered a head of the family means one has to be working in order to take care of the members. According to them if the head is not working then he is unable to provide for the family so the role of being a head is shifted to the one who has a job. An excerpt from an interview reads thus:

It depends on who is working in the family. You will find that the man is unemployed. The one who works has power. In our culture a man is the head of the family but these days anyone who looks after the family with their own money can be the head of that family.

IDI, adult female, urban Limpopo

It is males but now it is going to depend on the one who has the ability to or I will be the head but have no money so anyone who has the ability can become a head, it does not necessarily have to be a man.

IDI, elderly male, semi-urban KwaZulu-Natal

The above are confirmed by findings from studies conducted elsewhere. Preston-Whyte (1993) reported that most households were traditionally headed by adult males, but in recent times there has been an increase in the number of female-headed households, (due to the death of the male heads) by elderly people or children as a result of the death of both the male head and spouse. Non-marriage has

also been identified as one of the factors contributing to the increase in the number of female-headed households. According to some both male and female-headed households were changing in composition as a response to domestic crises that arising from poverty and the movement in search of jobs or even simply a place to live.

Headship may reflect structures of authority that are age-related, as well as conventional differences in the ages between spouses (Murphy, 1991) that are more pronounced in African households (Posel, 2001). In addition Posel (2001) indicates that there was also a strong relationship between being the household head and the highest income-earner. Using the 1993 Living Standards Development Survey (Posel, 2001), it was found specifically among African households that, in more than 80% of all households, the head represented the highest earner in the household. When the highest income earners were not household heads, they were most often partners of male heads, or children of female heads.

4.5 Conflicts

The study also sought to establish whether there was conflict between the old and new generation. Conflict is divergence, difference or clash in attitude, knowledge or belief among the people. People can be aware of such a conflict or they may not be aware. An intergenerational conflict refers to divergence, clash and disagreement on interest, values, attitudes, knowledge and belief between on generation and the other. Conflict is a result of differences in perception. The perceptions are in constant change. The changes are a result of rapid changes in life in the areas of politics, economics, social life, technology and even changes in the environment. Each generation has its own perception of culture as it is informed by societal values. Newer values are a bi-product of newer generations. It is the metamorphosis of values that triggers conflicts between new and old generations. Some conflicts are among the same generation, new or old.

In the study, there are various types of conflicts. These conflicts have different causes and they have also varied consequences. Many of the conflicts that were discussed were between families or between spouses, rather than between generations of the same family. A conflict can arise between two families caused by a fight between two children who would be playing and then fight. In a focus group discussion conducted in Tshituni, one of the rural areas in Venda, for example, the teenagers indicated that conflicts start when one child beats another child from another family. When such a things occurs, it degenerates into a conflict between two families. The conflict created may prompt the two families to frown at each other for a long time before they sort out their differences.

It can be deduced from the interviews that conflicts between families result from family protection. It may also show that family members prioritise family support or protection. It can also be said that conflict between families strain relationships with neighbours and community members. One girl presented as follows;

> It starts when a child goes and beat certain child from another family. When this happens the mother of a beaten child starts to blame the family of that other child. By doing so, conflicts created between two families and it may take too long for them to speak to each other or reconcile.
>
> **FGD, young females, urban Limpopo**

> It is a split or disagreements at home that lead to division
>
> **IDI, young females, rural KwaZulu-Natal**

Jealousy among young people was mentioned as a source of conflict. The jealousy could be over partners, clothing, fashion and beauty. These tend to cause conflict especially among youths. As an example, a girl who dresses well, and has a nice body can be very attractive to boys. This may be a source of conflict to friends or peers who could be jockeying for similar attraction or position for the same boys. Normally, girls that feel inferior react by isolating themselves from others. This is a serious sign of conflict in a group. In a focus group discussion it was clearly stated that;

Even jealous of someone who dresses well among other girls may cause other girls in the same group to say bad things about her. For example such comments like, you are not beautiful or those clothes do not fit you can be easily passed.

FGD, young females, urban Limpopo

Over there that family living there have no head of the family, usually their mother visit them coming from the casual job. Neighbours do no assist them, a son who have been trying to support the family they shot him.

IDI, young male, semi-urban KwaZulu-Natal

Envy can also be seen among older women. That can cause conflict leading to hatred. One woman had this to say,

It can be that I am living lavishly with my husband. People can start telling lies that he is sleeping with someone. This woman will make me ask my husband. Whether he says yes or no my trust diminishes. Jealous will also to hate the other woman and her family.

IDI, elderly female, rural Limpopo

From the above statement, it can be seen that gossip can be detrimental to relationships. The information may not be correct, reaches unintended recipients, and generates suspicion. It is this suspicion that causes conflict in society.

Conflict is also caused by lust. A spouse can have a multiple relationships outside marriage. That can be a source of conflict. Some of the respondents agreed that some partners are not faithful. One elderly woman had this to say;

It (conflict) is caused by a situation where a woman is unsatisfied sexually by her husband. The husband erratically sleeps at home. The unsatisfied woman is forced to look elsewhere for sexual pleasure. If that is discovered by the husband, he may chastise the wife.

IDI, old female, rural Limpopo

My husband no longer feeds, as a result I am staying at home with my mother. It means I am now responsible for these children. He stays with another wife eSikhawini.

FGD, young females, rural KwaZulu-Natal

Those families do exist, reasons parents passed away or other causes. Parents were cheating to each other and that caused divorce.

FGD, young males, urban KwaZulu-Natal

A teenage girl echoed a similar sentiment,

Boyfriends can not be trusted at all. You will normally find that you are his third while he is the only one you

have. Guys like girls. They are not satisfied with one girl. We keep fighting with other girls for boys. Girls end up hating each other.

IDI, young females, urban Limpopo

In the above quotation women are said to be fighting each other as a result of male wrongdoing. Instead of teaming up against men that are cheating, they fight each other. This shows that something is wrong in the power relations of their love affairs.

There are also conflicts resulting from differences of values. As an example, there were reports of young people beating elderly people. The reasons that were cited varied. Some were being beaten for money, girl friends and other flimsy reasons. This is deviance.

Poor communication was also reported to be the source of conflicts among couples. In a group discussion, one woman said:

It's because there is lack of communication between couples. Some drinks.

FGD, young females, urban Limpopo

And also,

It may happen that the mother quarrelled with the father and separated and the mother ended up staying alone

FGD, young females, rural KwaZulu-Natal

The conflict between male and female causes the male to leave his female partner

IDI, adult female, rural KwaZulu-Natal

These remarks show that communication is important if conflicts are to be prevented in relationships. Alcohol abuse can also influence conflicts. Excessive abuse of alcohol can even lead to family breakdown. In as much as men where alleged to be chief culprits by women, they were equally vociferous about alcohol and other general forms of abuse.

I personally hate people or men who abuse or beat their wives and even women who abuse their husband. That kind of life I do not recommend.

IDI, elderly male, rural Limpopo

Females are very strong because some of the males are drinking too much and their families are collapsing. The painful thing is that the wife is left to try whatever way she tries

IDI, young female, urban KwaZulu-Natal

They are surviving. It is just that a person easily chases you because he knows that he did not sweat for you because he did not pay lobolo because if he paid lobolo for you he can never chase you. And, there are no jobs. People have committed themselves to alcohol because a person does not know what to do. I, for example, I stayed 17 years in my husband's home. No lobola was paid. I have five children but I am not married. Now he easily chased me because he did not spend his money on me.

FGD, adult females, rural KwaZulu-Natal

My brother quarrelled with his wife and beat her in dangerous parts, which led to her death and left three children. The children are living with me because my brother was arrested.

IDI, adult female, rural KwaZulu-Natal

In other places visited, respondents reported that most people get along very well and they do not see any problem with how people relate. While on the other hand some parents reported that sometimes there are conflicts especially when children do not listen to adults when they try to discipline them. Apparently children do not listen and they have no respect towards adults because they say they have rights and think that they can do anything they like. These are examples of intergenerational conflict within the family.

There are children of one lady she works in Pretoria and she has five children. The first-born is bully; he beat me with a burning wood. When I tell him that he is still young, he must not come back home late at night, he says he will tell his mother that I give him problems.

FGD, adult females, rural Limpopo

These days life is to longer enjoyable, children no longer listen to their parents. When they come back from school they watch TV. They adopt bad manners in the streets.

IDI, elderly female, rural Limpopo

You see life these days is different. The main problem is that government told children about rights so these children do not understand how these rights work. When you discipline them, they say you are abusing them and even leave home. So we as parents are faced with a big problem.

FGD, adult males, urban Limpopo

You get other people fighting with their parents for foolish reasons saying that parents are oppressing them. These rights re the ones that make people to fight with parents.

IDI, young female, urban Limpopo

There is dignity if there is a father but children are disrespectful if there is a mother only

IDI, adult female, rural KwaZulu-Natal

4.6 Summary

According to the findings of the study both females and males across rural and urban areas reported that a family consists of the father and the mother who are married and living with their children in the same house. They mentioned that even if those two people are not married or they don't have children they are still considered a family as long as they live together. The most common types of families that existed in different areas included the nuclear and extended families. Other families listed were skip-generation families which consisted of grandparents and grandchildren, child-headed families where children are staying alone without an adult member, as well as single parent family which consists of the mother staying with her children. There was an indication that there was an increase in the following three types namely skip- generation, child-headed and female-headed families.

When it comes to headship, culturally men were considered to be heads of families mainly because they are the ones who lay rules that should govern other members of the family and due to the fact that they are working and provide for the family. Women were only considered to be heads if they do not have husbands even though they are not called heads per se. Apparently it is preferred to say that women take responsibility for the children instead of saying that they are heads.

The study also intended to look at the issue of intergenerational conflicts but not much was covered around this issue. The main concern that adults raised was about children who do not respect parents because they think they have rights. In some cases, the source of conflicts between families was fights which arise between children or young members of the families and extend to involve the families.

CHAPTER FIVE

PARTNERSHIP PATTERNS

5.1 Introduction

The family is the basic or primary unit of a society[2]. In that most basic concept a family is traditionally known to start from marriage followed by childbearing, and these children are expected to leave home when they marry and establish their own families (Glick, 1957)[3]. The process of family formation forms an interesting area of study because it has traditionally been accepted that it is within marriage that most childbearing occurs. Entry into marriage and the proportions married are important no as determinants of fertility. Age at, and type of, marriage for women has implications for the health of women and for the children born in unions where the mother is, biologically and socially, too young.

Marriage for women in sub-Saharan Africa was once described as "early and universal" (Bongaarts *et al.*, 1984). Though the "early" part is now subject to variability, the universal part remains largely true. Childbearing starts soon after marriage, though in some societies proof of capability to produce children in the form of premarital conception may be sought and may act as an accelerator to marriage (Hill and Marindo, 1997). Marriage in sub-Saharan Africa has been seen as a process rather than a single event; making it difficult to tell as to when exactly one can be defined as married. The situation is rather different in South Africa. Chimere-Dan (1999) demonstrated the existence of non-universality of marriage and high prevalence of non-marital childbearing among African and Coloured South African women. This can lead to the conclusion that family formation in South Africa is not necessarily an outcome of marriage. The government of South Africa recently noted

[2] A family can be defined as a small group consisting of parents and their non-adult children living in a single household

[3] The question then becomes "What do we mean by marriage? Is it a relationship between two adults, male and female, recognized by a civil or religious ceremony or customary rights. If couples agree to live together, when does it become a marriage, etc. (see Worsely, 1977).

that marriage seems to have lost its value as a determinant of fertility (Department of Social Development, 2000).

Childbearing within and outside marriage can create a myriad of family types. It can be a small group consisting of parents and their non-adult children living in a single household (nuclear or biological family)[4]. A family can be made up of more than two generations of a biological family as in cases where children's spouses join the household (United Nations, 1958). Unmarried women may decide to have children and establish what is referred to as a single-parent family. The existence of single-parent families is not unusual in Southern Africa. Gaisie (1998) has reported the same observation for Botswana, Warren *et al*. (1992) for Swaziland, and Chimere-Dan (1997) for Namibia. Single parent families can also be a result of divorce, which is believed to be common in sub-Saharan Africa.

In addition to the historic predominantly male migrations to the mines and plantations resulting in break up of marital sexual unions and formation of extra-marital unions, recent studies have shown that the HIV/AIDS epidemic has played a key role in changing the family composition and structure in South Africa (see for example Whiteside and Sunter, 2000, Mturi and Nzimande, 2003). The epidemic might change age at first marriage, proportions marrying, and there might also be an increase of households headed by widows or children under 18 and orphans (Muzika-Gapere and Ntozi, 1995). However Ntozi and Zirimenya (1999) writing on Uganda, noted that, "[i]n spite of changes in size, structure and function caused by the AIDS epidemic, the African family has persistently maintained its place as the central human social unit. Whether in the nuclear or the extended form, the family has remained a network of people most of whom are connected by kinship".

[4] A person or a group of persons occupying a common dwelling (or part of it) for at least for four days a week and who provide themselves jointly with food and other essentials for living (Lestrade-Jefferis, 2000).

The following sections report on findings of the qualitative study, concentrating on some aspects of partnerships and, where possible, how these might have changed over time.

5.2 Marriage Patterns and Remarriages

Results of the RA exercise confirmed that there are a number of ways that a family can be formed and as a result there are a number of types of families, in the societies studied, confirming the results discussed in Chimere-Dan (1999). According to the older generation, in the “old days” families started with a marriage that was preceded by a love affair between a girl and a boy.

However, families can be changed when a girl still in her parents’ house falls pregnant, such as in cases where the man cannot afford *lobola* (one of the economic reasons for non-marriage and childbearing). This was cited as one of the main reasons why marriages were no longer a viable option for many young men and women, unlike in the old days. The research presented in Lesthaeghe (1989) also show how in traditional sub-Saharan African societies, economic independence of the man was very important. And so the statement “How can they pay *lobola* when there are no jobs?” makes a lot of sense. As one woman in Kwazulu-Natal put it “sometimes a couple might love each other for a long time up until they get children”. Marriage, according to a woman in the Eastern Cape “Its brought by working, first of all when you marry there must be money” and “Marriage is luck, its luck and how rich a person is. If you don’t have money what will you marry with, that is why people are not married”.

A large part of the views on partnership patterns collected in the qualitative study came from the older generation and the following accounts mostly represent the views of women in the Eastern Cape, where the economic means to marry, in theory, seems to be the most important determinant of marriage;

None, there are no longer marriages because there is unemployment. They don't want to support, there is no longer love, and a person loves you when you are near him, when he shifts from you, he gets another one, and there is AIDS. There is no longer marriages they don't want to support their children.

When men propose, will promise you marriage but he won't marry you.

FGD, females, rural Limpopo

The deception is however not only on the part of men, women too were mentioned as wanting “relationships” and even marriage simply because “It may happen that it is a person’s way of getting food from his/her friend because there is no food at home. It is just a way of ensuring that you have food before sleep”.

Marriages had become fewer and far between because the girls “misbehave”, they get involved with “this one and tomorrow is that one”. Women in the Eastern Cape also mentioned male out-migration as a major reason for non-marriage;

They make children with boys, so the boys leave them. These boys keep on proposing other girls, the urban girls. They left them because there are rural girls. They marry urban girls.

IDI, female, rural Limpopo

The marriages have decreased, we don’t know we are frustrated when children go to Johannesburg, they don’t come back home, and they go to Johannesburg forever. Those children they get excited of *kgatla* 's women and those *kgatla's* like their money not them.

FGD, females, rural Limpopo

In the examples shown above, where the unmarried girl introduces a baby into her father’s household the head of the family is the grandfather/ grandmother and he/ she will make the rules until they passed away and after that the brothers of the woman will make the rules. In cases where a woman moves out to establish her own household, she formed the head of that household, this was not thought of as unusual, but might be considered undesirable in the sense that they do not have the respect of marriage. According to a man in Limpopo,

Mostly in Seshego heads of the family differs. Both males and females are heads of the family. There is no longer a rule that say the head of the family is a male. Other families there are no men, is only woman.

IDI, male, urban Limpopo

Single and female-headed households might be more economically secure in cases where the woman is working. This was actually mentioned as being very desirable especially in cases where the man was not working and there were mouths to feed.

Domestic violence was one of the reasons why a woman might choose to keep her own household as demonstrated below:

I built the house and put the furniture in the house, I feed the children and I feed him. He works and I am supposed to give him the money to go to work. I used to give him money to buy the groceries, but he comes back home with empty hands. When he comes back he beats me up, you understand? He is drunk; this is alcoholic that he goes for in the Shebeens. I am saying then that, it's mother who are heads of homes.

FGD, females, semi-urban KwaZulu-Natal

While divorce did not seem like a common occurrence in all the sites visited, separation in the sense that a father and/ or a mother living away from the main household was common.

That is not common here, what we know is the situations where men leave their wives with children unattended and go to stay with a new girlfriend or another woman somewhere. And you would find that the man was the only breadwinner in the household, the mother is unemployed.

FGD, females, semi-urban KwaZulu-Natal

Speaking of a household that a respondent knew of:

They don't divorce they just leave her.
So in those families, are these mothers working who are left with these children, are they working?
Yes.

IDI, female, rural Eastern Cape

This was because of economic reasons where one might be working away and might visit once in a while or in cases where the man and the woman have gone their separate ways and do not even see each other often. While the following story does not fully fit into one of conventional marriage, cohabitation or divorce, it demonstrates the complex shape a family could take:

I separated with my husband here in Zwelitsha in 1982, he then used to stay anywhere in the township, he loved women, so my third child Madoda my husband left when he was ten years old, he came back when Madoda was 16 years old. I forgave him again and he stayed. In 1989 I was pregnant with another daughter the one that you see, as you see that they are of the same age, he then left me again and said this child is not his, he went away, in 1994 he came back at night by 24h00 accompanied by my uncle's children, he was carrying some goods with a black plastic bag. I forgave him and he stayed. It was not even in-94 maybe it was in-95 because he left me in -95 in December but then I was pregnant with this young boy that you see, since he went in -94 when I was 4 months pregnant till now.

IDI, female, rural Eastern Cape

5.3 Cohabitation

Cohabitation was reported to be “common” especially where the woman’s family had already received cows for *lobola* but the couple had not had a ceremony yet (as above, some men might not have the ability to pay *lobola* especially if they are not working.) This is in line with what has led some demographers to define marriage as a process rather than an event. Cohabiting unions might be problematic and might not be able to ‘pull together’ as a family since they usually have problems that cannot be easily solved as if the couple were formally married. There was a view that “proper” families are different; in that couples that are married were sprinkled with “gall” making it harder to split. In the case of unmarried couples, if there is conflict another person just says he/she is tired of feeding another and just leaves because there is nothing binding them.

Cohabitation also occurred when divorcees meet other people and decide to live with them without a formal marriage and these might be better families than before. Generally, there is in no conclusion that cohabitation might be a more disadvantageous form of marriage than other forms as exemplified by the comment “I do not see the difference because they are also living well except that they are not married”. Cohabitation might also be forced by the woman’s relatives if the father of the children refuses to pay living expenses if the children do not live with him. Cohabitation without marriage and in cases where *lobola* had not been paid was however deemed “unfair” on the part of the girl’s parents who do not “gain” after all that they have done to feed and raise her. Cohabitation, especially in cases where *lobola* had not been paid, did not command the full respect of the community;

According to your view, how are these families that are not married doing if you compare them to families of married people?
They are surviving but in at the end it does not have good effect because for those who are not married, they end up losing respect. No one cares about another because they did not pay ‘‘*lobola*”.

IDI, female, rural KwaZulu-Natal

5.4 Multiple Relationships

Multiple relationships, such as those where fathers would have affairs with women from different households, were mentioned as being rare; and if there were any then these were hidden and never in the open (maybe a reason why they are thought to be rare). There was mention of “temporary families” where a man who is “easily attracted to girls” would use his “wiles” and promise material things to a girl who would form a house with him, though he might have another formal relationship elsewhere. Open multiple relationships were more common with younger men and women. Multiple relationships such as those where the husband (usually) would have a different household and family somewhere were frequently reported by women, especially those in rural areas and especially those in the rural Eastern Cape where a male who migrated due to unemployment seems to be a big issue in disrupting marital life, probably creating other forms of unions that have been found to be emerging by Mturi and Nzimande (2003). Not only did this lead to marital disruption but also it was one of the main reasons for poverty reported by the women left behind, as exemplified by the excerpt below:

There is no longer a marriage, because those who are married struggle like the unmarried. Men left them and go to the *Makgoweng.* When they are at *Makgoweng*, they forget about their families, they care about *Makgoweng.* When they at *Makgoweng*, they don’t remember their women, they take care of the women in *Makgoweng*. They only return home when they are ill.

FGD, females, rural Limpopo

Women did what they could to work and in most areas, such as Kwazulu-Natal, the women did work, but in the Eastern Cape work was scarce;

They don’t take care of their families. Is better to work for ourselves, but out there no jobs.

IDI, female, rural Limpopo

5.5 Concluding Remarks

The analysis has demonstrated that marriage and partnerships in South African society are not simple and straightforward. We have seen here, at least for the sites that participated in the qualitative study, that marriage can indeed be a process and not an event and that marriages and partnerships can take a myriad of styles.

However, the “means to marry” theory seems to hold ground in that shortage of men due to migration and shortage of men who have the means to marry can distort the marriage market leading to other forms of unions and partnerships. We also see in this report that, due to a number of factors including poverty, migration, deaths and other disruptions such as divorce and separation, there are many types of families that do not conform to the traditional definition of a family. These should be investigated in the forthcoming research. It will be imperative that questions are designed properly in order to capture the true picture. It is known that questions on marriage are some of the most difficult to design since “marriage” could mean something different to each person.

CHAPTER SIX

MIGRATION AND MOBILITY

6.1 Introduction

South Africa is characterized by high levels of adult economic migration involving migration from rural areas to employment opportunities both in rural and urban areas. It appeared that circular migrants moved between their rural households and their place(s) of employment. During these typical movements, return visits were made to rural areas either during holidays or emergencies or when employment ends (Hosegood and Solarsh, 2001).

Migration and mobility was one of the focus areas that were discussed during the study. Participants discussed several issues relating to the patterns of adult mobility in search for work and the effects arising thereof. Some of the issues touched upon include social effects of migration on families, remittances, and types of migrants and the interrelationship of migration with HIV/AIDS. Issues were discussed in terms of experiences of the participants as well as how they perceive things to be in other families. The topic was discussed during both in-depth interviews as well as focus group discussions.

6.2 Social Effects on Families

During interviews participants were asked about the social effects arising in families due to migration. Participants were asked about the effects of migration and mobility on households of migrant workers in particular. A question posed to participants was, “Are there families in this area where you find that some of their members are absent because they work far?” Then a follow-up question was, “What changes arise in such families as a result of migration?” Different views were provided regarding this issue.

A general feeling from most participants in Kwazulu-Natal about households of migrants was that those households lack dignity because the male head is usually

absent from home. According to some of the participants a household is respected when it has a male head because females do not have much influence when it comes to disciplining children. Thus some children from such families do not listen so they are badly influenced and get into trouble. When asked if there were any changes that people have noticed that are caused by the absence of other household members who work far and do not stay at home, some people indicated that life in those kinds of households is a struggle especially where children are left alone and there is no order because there is no adult member to discipline them. There were strong suggestions that the father's presence in the home has a lot of meaning since he is the one who lays down the rules that govern family members. If the father figure is not there then a child loses the sense of obligation to follow rules. The following are some of the statements reported by respondents.

Let's say in a household there are older boys. These boys will start not respecting the mother because they know she cannot discipline them if they don't want. They will only behave well if the father is around and once he is gone they misbehave again. You will find that they involve themselves with bad friends and they abuse drugs.

IDI, male, urban KwaZulu-Natal

It is better if the mother is at home instead of having both the father and the mother working far away because sometimes there are problems. That family usually lacks dignity and face problems.

IDI, female, semi-urban KwaZulu-Natal

It affects children most because children are still growing and they need guidance. We find them with no one to guide them towards the right way.

IDI, female, rural Limpopo

In the family there should be an adult because the family, which I am talking about, children do parties and boys sleep in the house, there is no order.

IDI, female urban Limpopo

We do try to help but you will find that the children will tell you that, 'why are you worried because you are not our parent?

FGD, females, rural Limpopo

It depends on how the parents have taught them discipline. Sometimes those who have parents have no manners and those who don't stay with their parents have manners.

IDI, female, urban Limpopo

The thing is we tend to misbehave; the young children we live with are not properly fed and supported accordingly. We like to go for entertainment first and children that need our assistance are forgotten and do not get proper training and advice.

FGD, females, rural Eastern Cape

There was another major problem that was mentioned in terms of criminals targeting those kinds of households. That is households where fathers work far away get

broken into easily and things get stolen and family members end up being abused, generally criminals take advantage of households where there are no males. Some of the statements from respondents are given below.

There are problems that emerge like breaking in of households. Others steal livestock. They break in because they see that there is no male person in that home.

IDI, female, rural KwaZulu-Natal

Problems that are brought on to the family by the absence of the household head are that criminals take advantage of female-headed families.

IDI, female, semi-urban KwaZulu-Natal

In most of the rural areas around Kwazulu-Natal it was commonly reported that when fathers are away mothers are usually the ones left behind to take care of the household and children's needs as the following example illustrates.

Yes, there are two children, they are studying. There is nobody to support them financially. Their mother depends on the grant, the same money they use when they are going to school, for transport purposes. They also buy food in the same money, because they need something to eat.
Their mother is getting money for her sickness.
Where is the father? We don't know, he went to Mazda to work, he never came back.

FGD, females, rural Eastern Cape

Most importantly mothers have to make daily decisions like looking after the children, buying food and clothes, paying school fees. However, when it comes to major decisions, the mother has to wait for the father to come back home because he is the head of the family. The following are some views from some of the respondents.

It means that decisions are taken by the one left at home, the mother because she is the one looking after the children.

IDI, female, rural KwaZulu-Natal

Because the mother is the elder person in the home when the father is away, she makes all day-to-day decisions by herself but has to wait for the father to make major decisions.

FGD, females, semi-urban KwaZulu-Natal

This appeared to be a common practice among most of the Zulu-speaking people. It is seen to be an ideal situation that at least the mother gets to stay with the children at home so as to provide proper child rearing and care while the father is away from home.

According to a study conducted by Posel (2001) in most households headed by male and female, there is usually a final decision maker and in most cases that decision maker is the head of the household. However, in male-headed household there is a gender division of labour in that men assume more responsibility for decisions concerning household production while women assume responsibility for household reproduction that includes spending on food, education and health.

There was a different scenario from the Northern Sotho and Venda speaking participants in Limpopo because it was indicated that in most cases both parents leave the household to look for work. In that case children are left in the care of either the grandparents or the nanny/auntie, though very few can afford to have child minders. Grand parents have to be responsible for their grandchildren because they are the only adults available. Whenever there is no grandparent in that household, children are left alone and the older child will be responsible for the other siblings. Typical comments include the following:

Because of unemployment parents work far from their families so the grandparents have to take care of the family.

FGD, young males, rural Limpopo

There are conditions where you find children are staying alone at home. It starts from when the parents have to go out and look for jobs and come back home during month-ends. Sometimes the father goes first and the mother will follow to look for temporary jobs.

FGD, females, rural KwaZulu-Natal

The same situation also appeared to exist among the Xhosa speaking participants in the Eastern Cape that children are either left alone or with grandparents. However, most respondents from the Eastern Cape indicated that there are many households where children are left alone because their parents died or they have left to go and seek employment somewhere else. In most cases it was indicated that relatives are asked to keep a close eye on the household and also try to support the children. Participants mentioned that the situation is difficult because in some families the children become a burden to the grandparents whilst in other households children

end up not going to school because there is no one to monitor them on a regular basis. Some of the responses are as follows:

Parents leave their homes because there are no jobs and they go to other places to look for jobs. They get temporary jobs which expire within a short while, back at home children stop going to school, life is not good at all.

IDI, male, rural Eastern Cape

Yes, I am staying with my grandchildren; both their mother and father are nowhere to be found. I only remember their mother who went to Gauteng to look for work and I do not know about the father. Their mother never writes or sends some money.

FGD, females, rural Eastern Cape

I am one of the grandmothers and mother who live with children. I'm staying with two sons and a daughter, another daughter went to Cape Town to find a job but she sometimes stays at home due to lack of jobs. Now I have grandchildren who are my responsibility. It's even worse, I have two children of my grandchildren, one of them I don't even know where the mother is. I went to Home Affairs, they said I must go and find her mother.

FGD, elderly females, rural Eastern Cape

This remark reflects some of the problems and challenges that some of the children and the elderly of migrant workers have to face on a daily basis since they do not get adequate guidance and support because they do not live with parents on a full time basis. A lot of difficulties are faced by these children, which include shortage of income to fulfil basic needs such as food and clothing, pay for school fees, lack of access to health care and lack of moral support

The above can be supported by a report from Bhengu (2001) that children who are left alone (especially orphans) lose several important needs in their lives. These include parental care, income as well as property rights leaving them impoverished and unprotected. Hence most of them have dropped out of school mainly due to poverty and lack of supervision.

One of the strongest concerns from most participants was the fact that some of the migrants desert their families. This happens when a partner leaves home to look for work in big cities like Johannesburg. It may happen that they do not come back home often, start having extra marital affairs and end up not coming back home totally. These then lead to a point where the partner forgets about the family and starts a new life in the city. While on the other side when the situation is like that the partner at home is also tempted to get another person who will support the family. Then all

these situations lead to conflict within the family and eventually dissolution of the family. Some of the excerpts are presented below.

Sometimes divorces and conflicts result due to dishonesty of men, maybe having affairs with other women where they work and get them pregnant or maybe the wife on the other side cheats by having an affair.

IDI, female, urban KwaZulu-Natal

In the first instance the husband goes to Gauteng and comes back home every month end because he hasn't got a woman yet. As time goes on, he starts phoning his wife telling her all sorts of lies about the situation at work. On the other hand the wife realizes that her husband is cheating on her, she also finds herself 'Sabelo' who has long been showing interest in her. She needs someone who is going to support her and the children because her husband is sending less money than he used to. This is how the household breaks.

FGD, males, urban KwaZulu-Natal

People who usually leave are men. They go to look for work and find women on the other side and the family that he left behind collapses. **IDI, female, urban KwaZulu-Natal**

It causes the wives of those men to sleep around with other men to be able to put food on the table for their children. A man leaves home for long periods of time and he does not send money so the woman just decides to do what they feel like doing for survival. When the husband finds out, then conflict starts.

FGD, females, urban Limpopo

I mean sometimes it happens that parents die or perhaps they go as people who are seeking for a job and they never return, the children end up with their grandparents.

IDI, female, rural Eastern Cape

This issue was a major concern from most of the women who were interviewed across the different provinces. They felt that this situation of partners working away from home is weakening the family ties. There was strong suggestion from most women participants in Limpopo that partners should live together and share the responsibility of raising the children in a stable home environment. This issue of partners living separately was seen as causing a lot of problems within the households because some of the people fail to stay faithful to their partners. The following excerpts give a picture of what these participants had to say.

To be honest it is very tough for us women when a man is very far like Turf or Jo'burg. We are supposed to be with them in their rooms, you know what I mean. These days I have to live with my husband at his workplace, explained one respondent. While another remarked, I am also afraid of this other woman who will wash for him, cook for him where he works and makes him give me less money. Life these days requires us to live with our husbands so that we can raise our children well.

FGD, young females, rural Limpopo

It doesn't have order because people are far from each other, they don't even have time for their children or even giving them moral support or anything.

FGD, females, urban Limpopo

This could be confirmed by Lurie, Harrison, Wilkinson and Karim (1997) who conducted a study on circular migration and sexual networking in rural Kwazulu-Natal (Hlabisa) that female partners of male migrants clearly recognize the fact that their partners take additional sexual partners while they areaway. Most men readily admit that they do take additional sexual partners while away though women are much more reluctant to admit that they are likely to be involved in extra-marital relationships.

Another important issue identified during the interviews was about how often migrant workers visit their homes. Interestingly, it was common around all three provinces that at least those who work around nearby towns manage to visit their families during month ends or over weekends if possible. However, those who work far can only visit either after three months or during major holidays like Easter or December. In some cases a person might even not visit for a whole year. Apparently different respondents were reporting according to their experiences and here is what some of them had to say.

Due to the fact that they are working very far they come back during major holidays like Good Friday and December.

IDI, male, rural KwaZulu-Natal

It depends on where they are working. Others take a week, others take a month, and others come on holidays perhaps on Good Friday. Others go home on any holiday they get. If a person did not use holidays then s/he will go home in December.

IDI, female, urban KwaZulu-Natal

Both males and females work away from home. Females sometimes come back after a month but males take three to six months to come back home.

IDI, female, semi urban KwaZulu-Natal

Maybe six months, some a year and come back on Christmas. Some every month-end.

IDI, female, rural Limpopo

Others spend a long time and others will even spend years without coming back and they are called “ukholwa” (meaning someone who is prepared to come home dead).

FGD, males, urban Limpopo

Their father comes home during December holidays.

FGD, females, rural Eastern Cape

How often migrants visit their homes was also attributed to whether the person is working or not and whether they can afford to go home. In addition most people leave for the city to look for jobs because there are no job opportunities in nearby towns. For some it takes them a while before they get a stable job, so whatever little money they get from casual work, they have to save it. The following are examples of what some respondents said.

My husband left for Johannesburg to look for work, he hasn't found any and is still looking.

FGD, females, rural Eastern Cape

Sometimes you cannot come back every time if you are working far away. You find that you don't have enough money to do so.

IDI, male, urban KwaZulu-Natal

It depends on whether a person found work because sometimes you find that you have no home, no shelter where you are going. You just say you will see when you get there. Perhaps you find a friend and then start looking for work and find it after three or four months. Then you start coming home. But it is also difficult to come home after your few months of work because you have to consider your expenses, like your children and their mother. I have to buy this and that and the money is insufficient then you come home after three months after having started working.

IDI, male, urban KwaZulu-Natal

She comes back anytime, she is working in Cawa. When she comes, she brings money to pay for debts.

IDI, female, rural Eastern Cape

A study by Lurie *et al* (1997) confirms the above findings that there is a relationship between the distances migrants travel and how often they are able to return home. They reported that since women migrate shorter distances, they are able to return home more often and maintain closer links with their families. For instance the majority of them are able to visit at least a few times a month while some are able to visit every weekend. When it comes to men migrants who work in the furthest destination like Johannesburg area, they visit their families less frequently. This is mainly due to the cost and time taken to travel back to Hlabisa that more frequent visits are generally not feasible. For instance, most of them are able to return home every 2-4 months for a long weekend while others return less frequently and sometimes only over the Christmas holidays.

Participants in Limpopo were asked where exactly the migrants consider as being their home. It was interesting to see that the majority of them consider their home to

be the homes they have left, that's where they come back to visit during holidays. Their home is where they left their wives and children, and where they grew up. However, there was an issue that was raised that there are some migrants who leave their homes and never come back home. The main problem was that the only time they come back is when they are dead or sick and they need family support and to be taken care of. The following excerpts reflect some of the opinions.

When they are at *Makgoweng* (Sotho word meaning big cities) they don't remember their wives, they take care of the women in *Makgoweng*. They only return when they are ill.

FGD, females, rural Limpopo

Their home is where they left their wives and children.

FGD, males, urban Limpopo

They consider their real home as where they are coming from.

IDI, female, rural Limpopo

Venda is their home because they still support home even if they die they will be buried in Venda.

FGD, males, rural Limpopo

It seems like most people are grandmothers who raise grandchildren, their daughters went away to look for jobs in Gauteng. Some of them are not coming back and some come back in coffins and the grandmothers have to be left with that burden of grandchildren.

IDI, female, rural Eastern Cape

This indicates the difficult conditions that some families of migrants, especially those headed by grandparents, have to face in terms of spending for the grandchildren and getting no assistance from migrants and in turn having to pay for funeral expenses for the death of the same migrants who do not provide financial support when they are away.

6.3 Remittances

According to Hosegood and Solarsh (2001) "remittances of money and goods from migrants are a major determinant of household livelihoods in rural areas where local economic opportunities are limited"'.

During the interviews participants were asked about the money that migrants send back home in order to support their households. It was reported across the three provinces that most of the migrants do send money back home. It was mentioned that

they send it either by mail or they ask neighbours to take the money with them and give it to the mother at home so that she uses it to fulfil household needs. Most importantly on one hand, those who cannot send money buy food packages and send them by truck to be delivered at home. On the other hand if there is a grandparent who receives a pension in that household, that money is used to fill in the gap. This means that the pension is no longer meant for the granny's needs but has to be used for other purposes like filling the whole household's needs. Apparently most households across the three provinces depend on the pension money as their source of support.

Ardington and Lund (1995) were of the opinion that households that contain aged people were more likely to be able to survive without having someone in employment particularly if they were in receipt of pension. The following statements give a picture of what respondents were talking about.

> The ones I know are not struggling because they get money frequently from their parents.
>
> **IDI, female, rural Eastern Cape**

> The problem we have as women is that we have husbands who go away on jobs because there is no work. When they get to those places they forget about their families and have fun. The father leaves his children and does not know what they eat, what they do for school. For example, I have tree children, one is doing standard eight, he does not have school fees, he did not even finish last year's fees. Those are some of the problems we have because there are no jobs for us as well.
>
> **FGD, adult females, rural Eastern Cape**

> My parents are employed in Johannesburg but they don't send us any money. Our grandmother is trying but we don't get satisfied. She uses her pension to buy grocery and clothing and also pay for our school fees; she also has to pay her medical expenses from the same money.
>
> **IDI, females, rural Eastern Cape**

This reveals that at least some households with grandparents who have a pension are able to put food on the table when migrants do not send them money. But the pension cannot usually cover all household expenses since it is too little in most cases.

This can be evidenced by findings from Samson *et al.* (2002) that 84% of pensioners live in households with non-pensioners. So it is likely that these old age pensions are

likely to support people beyond the immediate beneficiaries. Kinsella and Ferreira (1997) also reported that the role of public pension in South Africa goes beyond mere support of the elderly. They further indicated that the sharing of pensions, particularly in African households, is the norm.

In Kwazulu-Natal it was reported that some mothers at home experience problems when the money that the father sent is finished by the middle of the month. That means the family will not have food to eat, and they do not have means to get additional money so the only way is to ask for food from relatives or neighbours, or a few Rand which will be paid back at the end of the month if the migrant manages to send money. In such situations females are forced to go and work at the farms or in the townships to earn a few Rand so that they are able to put food on the table. Others try to sell fruits and vegetables at the markets on a daily basis. Here are some of the responses.

There are problems, for example, children will come back with school needs and perhaps the father has not yet come back and he does not even have that money. The mother is still waiting for the father to post it. Sometimes you run out of food at home and the father does not post the money, that is another problem.

IDI, female, urban KwaZulu-Natal

What I do is that, like last weekend, I go home to my family to ask for something to eat because it is difficult to go around asking for food from people for the whole month.

FGD, adult females, rural Eastern Cape

The father of my child does not support her so I try to go out and look for temporary jobs. I survive by doing washing for other people.

FGD, females, rural KwaZulu-Natal

Casale and Posel (2002) confirm the above statements by reporting that recently women are being pushed into the labour market with the decline in access to male income being an important reason. This may be attributed on one hand to the increase in male unemployment and on the other hand the greater possibility of migrants settling in urban areas, which could be associated with reduction in remittance transfers to women in rural areas.

Some respondents in the Limpopo also mentioned similar experiences that migrant workers try to send money home every month so that grandparents can buy food and other basic necessities for children. But because of the fact that most mothers work in nearby towns they are able to go home every month end to buy whatever is needed.

The mother sends money, she does not have a problem when she is back we enjoy and eat everything.

FGD, young females, rural Limpopo

Unfortunately men cannot afford to come home that often because they work far away and have to think of their travelling expenses. In those families where no money is sent the grandparent has to use pension money to buy food and pay school fees for the children. The following are some of the quotes extracted from interviews.

We live with their children peacefully, these migrants don't support their families, and they depend on the money of the grandparents.

IDI, male, rural Limpopo

They don't live well because sometimes they don't even have food at home. It will be the wife and the children who suffer because the father doesn't send money. Then the grandmother is the only one who will help.

FGD, females, rural Limpopo

We really have a problem here. As you see my neighbour here, she works in Pietersburg and the children are left alone. They are very little children and she does not have a stable partner to live with. The children are really suffering and are giving problems. The mother sends them some money but as children without elders they misuse the money and end up not buying necessities.

IDI, female, urban Limpopo

Some respondents felt that migrant workers no longer sent money back home because all their money is spent by the partners they get involved with at their places of work. Here is what they had to say.

Men get *Bakgathla* girlfriends (meaning Tswana women) and give them babies, and they forget about their wives back at home so the money is given to those girlfriends". Another one commented; " The problem we have as women is that we have husbands who go away on jobs because there is no work. When they get to those places, they forget about their families and have fun. He leaves his children and does not know what they eat, what they need for school. For example, I have three children, one is doing standard eight and he does not have school fees, he did not even finish last year's fees. Those are some of the problems we have because there are no jobs for us as well.

FGD, females, rural Limpopo

Since our brother went to Gauteng, he never came back home and he left a wife at home, we even told the wife to

go back home, we are too poor to support her, she will even die in here. The one at Gauteng gets everything she wants.

FGD, young females, urban Limpopo

A study by Sadasivam (2000) confirms the above findings that unprecedented changes in family forms and household composition are mainly due to migration. Thus male migration has meant that in many households women have to be responsible for taking care of the children as well as earning income. Therefore, a higher and more severe incidence of poverty in these female-headed households is evidenced than in male-headed ones.

6.4 Types of Migrants

According to Posel (2001) approximately 7% of all households in South Africa represent male-headed households with the head being absent. In addition 96% of these were African households and more than 90% of these African men were reported to be migrant workers. Basically lack of job opportunities in nearby towns is the reason why people leave their homes to go and look for work far away.

Responses from the study seem to confirm the above statements since it was a common understanding that males are the ones who usually leave their homes to look for work. Most participants from Kwazulu-Natal reported that in their areas it is usually men who migrate to distant cities like Johannesburg to look for work. However, with changing times, females also go out and look for work though there are very few of them and they usually do not work far away from home, for instance they work in Durban.

Men are the ones who regularly leave to work and they can be gone a month or two, meanwhile the women remain at home. Mainly men leave home to work far but some women do even though they are in small numbers.

IDI, female, semi urban KwaZulu-Natal

I would say it is the same because males are leaving but I also see women leaving in few numbers these days.

IDI, male, urban KwaZulu-Natal

Findings from Lurie et al (1997) confirm the above statements since they showed that Johannesburg (32%), Durban (20%) and Empangeni (20%) were the three most common migration destinations for males. While the main destinations for females included Nongoma (one third), Durban (22%) and 45% are spread out between Durban and Hlabisa. Interestingly, findings showed that no women migrated to Johannesburg or any of its environs.

Migrant labour had a significant impact on household composition because of the potential loss of at least one parent from the household; in addition, female migration had major implications for child-rearing and child health. Tollman, Herbst and Garenne (2001) found a phenomenal magnitude of migrant labour among the Agincourt population in the Limpopo. A good proportion of people in the census were migrant workers. Between the ages of 25 and 59 years, 50% or more of all males were migrant workers while more than 60% of those between 30 and 49 years were also migrant workers. In the same age group, some 14% of women were migrants, a phenomenon that deserved further study. These women appeared to have substantially fewer children, on average, than their non-migrant counterparts.

Interestingly the same situation was also reported in some parts of Limpopo during interviews: that in most of the households both parents go out to look for work but most females find jobs in nearby towns while men go to far away places like Pretoria, Kimberly or Johannesburg. The reason why women get jobs nearby is that they usually work as domestic workers in the townships or suburbs. Men do not get jobs easily because most of them get heavy-duty jobs in big cities so that is why most of them have to work further away from home than women do.

These days migrants are both males and females because things have changed but women are not that many

FGD, males, urban Limpopo

It started long time ago wherein men had to go and work in Gauteng but these days even women do so.

FGD, males, rural Limpopo

However, a few respondents from Limpopo felt that these days migrants no longer exist or there are only very few of them because there is lack of job opportunities. So most people are no longer leaving their homes to look for jobs far away.

No the migrants are not there because places where they used to go like Gauteng, no longer have jobs. They used to be there but these days they are no longer there. When we grew up we knew that at Easter people will be coming with loaded bags from Gauteng, but today there is none

FGD, adult females, urban Limpopo

No we cannot call the youth migrants because when they come back home from Makgoweng they have nothing and their first stop when they come home is shebeens.

IDI, elderly male, rural Limpopo

Migrants? Last time I saw a migrant was in 1993, these days I don't see any.

FGD, females, rural Limpopo

There was a problem reported by some respondents in Kwazulu-Natal about young women who leave their homes to look for work. They mentioned that these women usually leave their children with the grandmothers and say that they are going to look for work. Unfortunately some just enjoy staying in those cities and they are not even working. The only time they come back home is when they are sick or pregnant and need help in taking care of the baby. It was indicated that this is a problem because they contribute in deepening poverty that already exists within those households. Some selected excerpts are as follows.

In many times females go and say they are going to work but come back with nothing except for sorrows; a person comes back being pregnant.

IDI, female, rural KwaZulu-Natal

Sometimes there are problems because some of them come back when they are sick. There is no work in our area so they have to go and work for their children in Johannesburg. I do not know how they behave themselves there because one comes back when s/he is sick and we have to bury him/her.

IDI, female, urban KwaZulu-Natal

Hosegood and Solarsh (2001) also reported that many labour migrants have restricted living arrangements and limited social networks in the towns and cities. These migrants made return visits due to pregnancy and illness. Typically, female labour migrants returned to rural households late in pregnancy for their family support.

6.5 Interrelationship with HIV/AIDS

Most female participants from KwaZulu-Natal and Limpopo were very concerned about partners who work far from home. They indicated that some men have casual sexual partners where they work and when they come back home they bring with them diseases. They also indicated that the main problem is that most men do not really believe that AIDS exists and they do not want to use condoms. So they are at high risk of contracting the disease and in turn put their partners back home at risk of getting the disease. Here are some of their views regarding this issue.

If my husband is a migrant my life will be unsafe because I'm scared of diseases and I wouldn't even know the life of his girlfriend, whether they use a condom or not. I am scared of diseases because I don't want to die and leave my children. Diseases go along with migrant workers, isn't it they say they don't want condoms?

FGD, young females, urban Limpopo

When migrants arrive in Gauteng they take other wives and stay with them. They sleep with them, after that they get illnesses, it is not safe. Their money goes to prostitutes. The radio-spread information about AIDS, explains what AIDS is and the cause of it. But we don't believe, if we can believe that AIDS exists, we can reduce the rate of infection.

IDI, adult female, urban Limpopo

It doesn't look good because you'll find both of them cheating each other with different partners and this brings diseases such as AIDS.

FGD, males, Rural Limpopo

Migrants bring diseases from Gauteng, they come back with diseases and they don't support their families.

FGD, young females, rural Limpopo

A study by Gebrekristos and Lurie (2003) reported that migrant labour system encourages risky sexual behaviour in South Africa. The system developed circular forms of sexual networks between rural areas and labour centres. They reported that miners have sexual partners at the labour centres while they continue a long distance relationship with their regular partners back in the rural areas. They continued to say that there is some evidence that miner's partners also have other sexual partners while their husbands are at the mines though less is known about those partners.

6.6 Summary

At times families dissolve since the husband and wife stay away from each other for extended periods of time due to migration. Some families get deserted by their

breadwinners who work far away since they start new families in the cities. Interestingly migrant workers make infrequent return visits back home and financial support in most of those families is deteriorating. People felt that these days there is change in the patterns of mobility because both men and women go out to look for work far from home. However, there are those who indicated that migrants no longer exist since there is lack of job opportunities. Some females mentioned that men who migrate put their partners at risk of getting diseases like HIV because they form extra marital relationships at their places of work. What is interesting was the fact that they did not mention the fact that some female partners back home might also be involved in those kind of affairs of which might put their migrant partners at risk.

CHAPTER SEVEN

SEXUAL AND REPRODUCTIE HEALTH AWARENESS

7.1 Introduction

The emergence of the HIV/AIDS epidemic as a major health threat has increasingly changed researchers reluctance to study sexual behaviour and issues of reproductive health (Preston-Whyte, 1994). As far as efforts to understand the spread of HIV/AIDS and other sexually transmitted diseases are concerned, the aim of most researchers has been to identify behaviours that propagate the spread of the diseases. In trying to stem the spread of the epidemic, understanding the degree of knowledge, the perceptions of risk and behaviours is vital. The main shortfall of much work on sexual behaviour is that they have discussed sexual behaviour mainly within marriage, which paints an incomplete picture.

Another motive for studying sexual behaviour has been concerns about the extent of premarital sex and childbearing in many societies (Preston-Whyte and Zondi, 1991). Researchers have been forthcoming in looking at what determines the age at first sexual relations because of the implications to health, loss of education, and risk of sexually transmitted diseases (STDs) for adolescent women. Similarly, there is an increasing interest in looking at the number of sexual partners that adolescents have, as well as their knowledge and level of contraceptive use.

Less explored and studied is the male side of sexual behaviour. The reason for this could be that unlike women, there are no direct health risks of underage pregnancies, or loss of educational or other economic opportunities. There has however, recently been an increase in the number of studies describing male sexual behaviour, mostly in relation to risks associated with the spread of AIDS. These studies, therefore, mostly concentrate on the number of sexual partners. On other aspects of sexual behaviour (eg. socio-economic determinants and consequences of early fatherhood), little has been researched.

This chapter presents results from the qualitative study and covers different aspects of sexual and reproductive health awareness including knowledge of STDs including HIV/AIDS, prevention / practices, attitudes, sources of information and family planning.

7.2 Premarital Sexual Relationships

There is growing evidence that a significant number of young people have their first sexual experience before age 14 and that boys start to have sex significantly earlier than girls do, and in greater number (Biddecom and Bakilana, 2003; Preston-Whyte 1994).

Shell (2000) in analysing the cultural factors of HIV transmission in the Eastern Cape highlights nuptiality rates and traditional marriage patterns as some of the factors that have influenced premarital sexual relationships. Shell (2000) argues that premarital sex patterns occur because of the change in traditional marriage patterns. He argues that due to high unemployment and general poverty in the Eastern Cape, *lobola* cannot be raised easily and therefore traditional marriage patterns fall away. As a result of socio-economic circumstances, young men and women move to cities in search in jobs. The circumstances in cities tend to make young women more vulnerable and this result in a drop of the age of first intercourse and an increase in high risk sexual behaviour. Shell (2000) also shows how traditional practices such as *ukumetsha (*making love without penetration) have fallen away thus increasing the risks of unsafe sex.

Flisher *et al.* (1993) also reports a substantial percentage of teenage schools girls who had vaginal intercourse with the median age at first intercourse being 14.9 for males and 15.6 for females with an average number of sexual partners ranging between 1 and 1.5.

However, adolescents' knowledge on reproductive function and sexuality is generally poor. A substantial number of young people have indicated that they need information on matters such as pregnancy, STDs, sexual intercourse and relationships.

South Africa has been found to be one of the countries in Southern Africa with the highest prevalence of premarital fertility. Garene and Zwang (2003) present a geographical pattern of differences in premarital fertility prevalence in Southern Africa with South Africa having about 57.8%. Preston-Whyte (1994) shows in the study in KwaZulu-Natal that the high positive value attached to fertility in African families contribute to the prevalence in premarital sex as the lack of marriage is not seen as an impediment to bearing and raising children as birth is the proof of fertility in a girl. She attests that the corollary of placing a high value on fertility is that most parents accept the non-marital children of their daughter's and son's by giving them care in the home and in so doing, they remove the real sanctions against premarital sex.

Along with the issue of premarital sexual relationships is teenage pregnancy. Premarital sexual relations among young people were reported as being overwhelmingly common and most respondents both young and old answered that young people were "going to the mat" before marriage. Such relationships are seen as having negative consequences not just of HIV infection but also because of the economic consequences of early childbearing. A typical response to the question as to why it was a bad idea to have premarital sexual relations was that you can get a child and disease before marriage. Views on this phenomenon were that it is a recent one; and that older people did not used "to do that" when they were at a young age and awaited marriage. There were however descriptions by the older men and women regarding the extent of premarital relationships, for example the mention of the use of *ukusoma* (thigh penetration). In their days people practised *ukusoma* and some elders advised that young people should practice that instead since it did not lead to pregnancy or diseases. The following typifies a response by an older woman who explained what used to happen in their days. In response to a question: "what is

your opinion about people who have mat relationships before marriage?" the response was:

This was happening before. But it was happening in accordance with good Zulu values, not what is happening today.
Listen my child. You see, when we are growing up, young men came from all over the hills to propose us. If you started feeling love for one of them, you told your sisters that now I love him. Your sisters will prepare his gift and tell that young man how things were going to go. The young men will be given love and a handkerchief will be flown in his premise. A handkerchief was a sign that a girl was involved in a love affair. You never come close to a man.
We were told that a person should not "eat" your father's cattle. We were also told that you must not open your father's kraal. Close the kraal and open it when you are married.

FGD, females, rural KwaZulu-Natal

The main concern of parents, and this was cited by elders, was that children "did not listen to them" anymore, and their advice to delay sexual relations were taken as abuse and an infringement of their human rights to do what they want. Children were also seen to listen and take advice from their friends, more than they do from their parents. According to this respondent:

In the family I am a parent, as a parent I am unable to control my family, because our children don't want to be disciplined. Children are dying because they don't want to be disciplined and they don't understand. When we tell them that there is AIDS they say they have condoms. When they die I must be responsible for their death.

FGD, females, rural Limpopo

Preston-Whyte (1994) argues that the acceptance of children from non-marital unions in a family sends mixed parental messages and are inconsistent to the children. She attests that adults or parents attempt to pass a message to girl to "keep away from boys" but in welcoming a daughter 's child into the home, are negating their ban on sex and babies before marriage.

Poverty was both a reason for; and a consequence of, premarital and early sexual relationships. Preston Whyte (1994) posits that within the South African context African poverty has had a number of effects on domestic life that affect sexual behaviour. Crowded and ghetto conditions, long irregular working hours and lack of recreational facilities make domestic control of children very difficult and for many girls, there is nothing to look forward to except childbirth. Preston-Whyte (1994) has

also shown that the adult men she called “sugar daddies” are becoming a financial resource for teenage girls whose parents cannot afford to support them materially. These premarital relationships put an economic burden on grandmothers, who have to take care of resulting grandchildren, in addition to spreading “mat diseases”. The child support grant was also mentioned as one reason why young women were tempted to have children at a young age. Even when a young woman still lived with her parents they no longer have to “suffer” because they get money, a young woman can give birth once and when that child is above a certain age the pattern can be repeated so that one can continue to receive the grant.

It was also mentioned that poverty within the family that a girl grows up in could drive her to seek relationships outside. An elderly woman in Eastern Cape said with resignation:

> Where parents cannot afford to buy things and presents for the children the boys might turn out to be thieves while “if it is a girl, she will find a boyfriend, a taximan or bakery or truck driver because they will give her pocket money. Therefore the taximan ask her to have a baby then the girl give birth. … The responsibility is for me because I am the mother”.
>
> **FGD, females, rural Limpopo**

Leclerc-Madlala (2002) in her Kwazulu-Natal study has explored sexual culture and context and how this links to contemporary sexual relations and behaviour. She found that most women get involved in what she terms “sexual economy” to secure basic needs, fashion accessories, prestigious outings, etc. She argues that such a sexual culture has a role to play in increasing one’s risk of being infected with HIV. Harrison *et al.* (2001) also demonstrated how girls would become involved in sexual relationships for material benefits.

Another example of the economic motive in sexual relations is seen in the following passage where a young man was describing the reason why the youth was the age group most affected by the HIV/AIDS epidemic:

> People between the age of 15 and 21 are the most infected. Its because Musina is at the boundary of the country to Zimbabwe, so there are big trucks from Cape Town and other places which come and park there. If you go to the border, you will see these teenagers like those who are playing there, with truck drivers during the afternoon

at around 6pm. Even the mayor tried to stop this behaviour but it did not work. They have turned that place into a playing ground. This is why the virus is spreading so fast in this community; those teenagers sleep with those men and also sleep with their own boyfriends.

IDI, male, urban Limpopo

7.3 Knowledge of Sexually Transmitted Infections (including HIV/AIDS)

Several studies have demonstrated adequate to high levels of HIV knowledge among South African youth. Varga (1997) reporting a KwaZulu-Natal case study found out that about 81.2% of youth in KwaZulu-Natal had adequate HIV/AIDS related knowledge regarding prevention, acquisition, transmission and consequences of infection. The communities covered by this study were aware of some of the many sexually transmitted Infections (STIs) that an individual can suffer from; this was true of the young as well as the old. Knowledge of STIs seems to be high and this was even true in rural areas where such diseases were known in the local language. It is however understandable that knowledge of HIV/AIDS and ensuing discussions overshadowed the discussions around the other STIs. Moreover, a reviewer of the transcripts often got the view that interviewers did not find the discussions on other STIs as useful since questions were rarely probed further, a deficiency that will hopefully be remedied in the next step of research.

Discussions among individuals regarding the other STIs did not seem to be as common as were discussions about AIDS. However participants were able to give symptoms such as:

You will have yellow discharge, the urine is hot, you also feel the pain.

IDI, female, rural Limpopo

When asked what sorts of diseases were known, a man gave a description of gonorrhoea:

Gonorrhoea is a disease that causes sores on a bladder and if is ignored it can develop on a penis and causes sores all over it. It produces a yellowish discharge when a person is urinating and a person may scream of pain during the process.

FGD, males, rural Limpopo

Other diseases mentioned were *drop*, which was described by a young man as:

It is a disease, which is contacted when you have sex with a woman. A man will develop an itchy penis with droppings like sperms out of his penis, which smells very bad.

FGD, young males, rural Limpopo

Individuals also mentioned *thosola* and *thusula*, which were said to be curable by traditional doctors. When asked whether people around used traditional medicines, the response was that:

Yes, they use them too much. If you have a problem and you want traditional medicine, firstly go to the clinic to ease that pain then you go to traditional healers to treat the disease.

FGD, males, rural Eastern Cape

Thusula was described as follows:

You can see it if you slept with a man who has it, a man's penis becomes green on front. When you urinate it smells bad and you get drunk of the smell and fall. After urinating a person falls.

IDI, male, rural Limpopo

The range of knowledge of HIV/AIDS ranged from completely never having heard of it; having heard of the disease but not fully grasping what it meant, to those who had not only heard of the disease but had quite detailed knowledge of it. In general, the majority of participants' knowledge of HIV/AIDS came from hearsay; and rarely was this knowledge obtained from well-informed sources, and was therefore in many cases incomplete or completely false. For example when asked 'Is there anything you know about HIV?' the typical response was "No, I have only heard about AIDS. They say it but I do not know what type of a disease because I do not even know that virus," or "No, I do not know it. I have not heard about that. I have just heard about the three word" or "I hear from people saying as you are saying, but I can't explain that this is HIV and this is AIDS. I do not even know it." As an old man in Eastern Cape puts it, " rumours say it is caused by sex". For many of the less informed participants the disease held them in a grip of fear, not knowing how to protect themselves. For example:

We in our community we are still scared of having sex, but we don't know the illness. We just heard people talking.

FGD, males, urban Limpopo

You will know you have it when your inner clothes have stains.

IDI, female, rural Limpopo

There were however those participants who knew quite a lot about the disease, in addition to just 'having heard about it' to exactly why the disease eventually kills. For example, responses to the question 'Do you know anything about HIV?' included

I can say HIV is when you have just contracted the virus and has not made you sick.

FGD, males, rural Eastern Cape

That is when you do not have AIDS but HIV. That is when you are not sick and your red blood cells can still protect you but when they cannot, you have AIDS.

FGD, females, rural KwaZulu-Natal

AIDS is when you are sick and sleeping down. It is when you have sores but HIV is when you are still well because you get sick and get better. That's where the difference lies.

IDI, female, rural KwaZulu-Natal

It means it is related because HIV kills the soldiers of the body and then the disease emerges and easily penetrates when the soldiers are not functioning.

IDI, male, rural KwaZulu-Natal

Discussions on how the infected people contracted HIV showed that messages about the sexual mode of transmission had been received by most people. It was however also clear that such messages were not fully understood as to exactly how the virus could be transmitted through sex, the following demonstrates this "one got it through the mat" and "when one does not use the 'coat'". Having sexual relations with more than one partner (or one's partner having more than one partner) was also understood as the way that HIV got spread, for example:

AIDS is an incurable disease, it affects a person through sexual intercourse, or by blood. But one cannot get AIDS from the mosquito bite, by sharing food and a kiss. The symptoms of a person who has AIDS, the immune system is weak, and any disease that can attack him it may be TB or flu it will be strong, because the immune system is weak. **IDI, male, rural Limpopo**

I fall in love with a person and then that person leaves to work in Johannesburg while I remain at home and loyal to that person. Meanwhile, he gets to Johannesburg, finds girlfriends and he comes back to sleep with me and that

is how I get infected with the disease. Or I sleep with another person in the absence of my lover and that is how he gets it. In that way, if you do not use the 'coat' the virus is spread.

IDI, female, rural KwaZulu-Natal

It is sleeping without a condom because as we are here, there are people who have two or three (Partners).

IDI, male, rural KwaZulu-Natal

There was also knowledge that injections with needles used by people with AIDS can also lead to infection as well as using a razor to make body cuts such as those performed by the herbalist. Also helping a sick person or in an accident while you have a sore without using gloves.

It can happen that one of the family members contracted it through the mat. Perhaps you will find that another household member was negligent because people are not well informed about AIDS. People tell themselves that it is contracted only through the mat. You can touch an injured person carelessly whilst you are not wearing gloves and you have a sore. Then his/her blood will flow into your body due to your carelessness.

FGD, females, urban KwaZulu-Natal

It was also known that it was difficult to identify someone who had been infected. Response to the question: "Is there anything you know about HIV?" received responses such as "I have heard that it is not easy to see him/ her. You only see it if a person has done a blood test," or "It is that when a person is HIV positive it is not easy to see it with the eyes" and "AIDS is the disease which you cannot see it, you can only see it after a long time". There were however many statements that attempted to diagnose HIV/AIDS by the symptoms such as '"When it is AIDS, a person has the symptoms like coughing and a skin that has blisters" or "being thin, coughing, sores and diarrhoea".

Given the limitations in detailed knowledge of the epidemic and its mode of transmission, misconceptions abound and are typified by the following:

It can start with a tiny rash.
Some get it from a mosquito bite.
I don't trust men anymore. I also know that nurses in hospitals use the same injection on more than one person.
You can't get AIDS from an injection.
Ay my brother you can get it. You can also get it from kissing a person on the lips.

FGD, females, urban KwaZulu-Natal

The following also exemplifies not only a misconception about the existence of HIV but also about its origin. For these participants:

AIDS is not AIDS per se because AIDS is only a Western name. In our Tshivenda culture we call it sexually transmitted disease, which is easy to transmit and cannot be cured. But only African doctors can cure it. It was also mentioned that "some don't believe that AIDS is existing, they think that the Whites are threatening us".

FGD, males, urban Limpopo

They said AIDS comes from the baboon, and if infected, the person can spread it to others.

IDI, male, urban Limpopo

Yes in my culture I was told that AIDS started during creation, is just that it did not have a name by then. AIDS comes from a woman who had sex before she was treated by the African healers. It starts from the bones then develops to vomiting.

IDI, male, rural Limpopo

AIDS is caused by the condoms, because the condoms of the green love has contributed to the spread of AIDS. The person who made them used his own chemicals; we don't know the kind of fats he used to make them.

IDI, male, urban Limpopo

The following might be more a reflection of antagonistic feelings that some might have against foreigners and was only mentioned by a few people:

In my opinion this AIDS disease is a disease that comes from other places in Africa, but is caused by sleep around which is caused by hunger, where a woman is forced to sleep with a person because she is poor. Mostly it is foreigners who bring it.

IDI, female, rural Limpopo

Knowledge of people within their communities who are already infected was conflicting, with quite a number of participants saying that while there were people who were infected, they did not know whom these people were.

Yes, but they are not many. You only hear about it when a person has passed away because his/her mother does not want to admit that his/ her child has a virus.

IDI, female, urban KwaZulu-Natal

Though this was the overwhelming response, there was also significant reporting of knowing that someone was infected by "looking at them", for example:

There are no people who disclose themselves but if you look at him/ her the way she describes it, you just see that AIDS has caught this one.

IDI, male, rural KwaZulu-Natal

Despite not knowing people who were infected or ill with HIV/AIDS, there was a degree of alarm about the disease that was mentioned. For example:

I do not know (someone who is infected), but I have seen very worried people looking for toll-free numbers to phone about that issue. Knowledge of treatment of HIV was very much limited to going to the clinic to get "pills". **FGD, males, rural KwaZulu-Natal**

7.4 Discrimination against People Living with HIV/AIDS

There was quite a significant proportion of respondents who voiced uncertainty as to how people who are infected with HIV are treated in their communities simply because they did not know who was infected. There was however significant reporting of someone who was distanced from the respondents because of the infection. A number of participants mentioned the "gossip" about people who were infected; pointing of fingers and laughing at them and that one cannot freely disclose their status for fear of being laughed at.

There was also mention of people "not doing anything" to those infected because those un-infected would simply run away and not want to be seen talking or associating with such an infected person. There was however reporting of "people who visit them" and who help them including counselling, this is however not universal since one could not give help the infected when "they do not disclose" their status. Non-disclosure was mainly because "they do not want the community to know what they are suffering from". There was discussion of families hiding the infected so that visiting them was made difficult. Only counsellors who knew who these people were made visits and carried cards with all the patients' information written therein.

There was mention of changes in perception about HIV/AIDS, for example:

It is not as bad as when this disease was new. They are now beginning to accept it. They feel sympathetic towards that person and show that they accept it.
We feel sorry for them because you also cannot know yourself if you have not tested it.

FGD, females, rural KwaZulu-Natal

7.5 The Use of Condoms

Preston-Whyte (1999) has explored the dilemma surrounding condom use in KwaZulu-Natal and brand this as one of the situational barriers to HIV protection in South Africa. Surveying South African literature on condom use Preston Whyte (1999) concludes that there is a growing sense of discontinuity and contradiction in condom use with regard to attitudes to condoms, protective behaviour and the trends in risk avoidance. This study also illustrates these contradictions well. Many respondents both old and young said that they talked about the need to use a condom, but this did not mean that they necessarily agreed that one had to use a condom. The young people knew of the condom, its usage to prevent pregnancy and its use as protection against infections such as HIV. This knowledge about condoms was acquired through school by the younger participants; and also through the social workers at clinics. Some of the older participants were all for the use of condoms and it was mentioned that it was important to insist on using a condom because one did not know "what he does when he is far from you" and that you must try wherever possible and "if he sometimes fails to use a condom, it is better not to visit each other". One elder person also mentioned that in addition to condoms, young people could also practice what they used to do i.e. *ukusoma* (thigh penetration).

Some young participants openly mentioned the reluctance among their peers to use condoms referring to "eating chocolate with its wrapper". Varga (1999) presents the same findings about the males' unwillingness to use condoms whereby unprotected sex appeared to be an integral component of a serious love relationship. The use of condoms in this study was also an important issue in defining the seriousness of the love relationship. As in Varga's study, this study also demonstrates that there seems to be a considerable resistance to condom use. Unprotected sex was favoured for

better satisfaction, spontaneity, while negative sentiments echoed about the condom relate to the condom as the main cause of AIDS. Varga (1997) concludes in the KwaZulu-Natal study that for youth/young people, the benefits of unsafe sex outweigh the risks of HIV/AIDS infection. These risk-taking behaviours are not only the means to spread STIs but also an important barrier to the prevention of HIV/AIDS.

They say they work to prevent those diseases like AIDS or others we don't know about. But we are not using them. Because they say you don't love me if you are using overall, I want flesh to flesh.

IDI, male, urban KwaZulu-Natal

When you discuss this issue with your fellow colleagues or schoolmates
Do you all agree on using condoms?
No, we disagree.
What is their view?
They say the condoms are the very things that contain AIDS.
Please elucidate.
They say in the olden days, there were no condoms no AIDS today there are condoms there is AIDS, they won't use them, they want direct contact, flesh to flesh.

FGD, females, rural Eastern Cape

In explaining why young people did not want to use condoms a number of other reasons came to light including the misconception that condoms bring diseases or that the youngsters were simply not used to using condoms and might forget to use them, or that they believed they were going to die anyway and that they do all these things when they are drunk. In one case a young man said:

I can say we don't use these condoms because most of the time we just go without preparing ourselves.

FGD, males, rural Eastern Cape

Varga (1997) shows how gender becomes a symbol of power in a relationship and Varga (1999) shows how Zulu males coerced their female counterparts in sexual decision-making. Selikow *et al.* (2002) have also explored the links between HIV, gender power relations, and overt violence and how these plunge South African youths, especially females, into HIV/AIDS vulnerability. Females cannot easily negotiate for the use of condoms because of the dominant males' decisions. A young woman mentioned that sometimes one did not have power to insist that a boyfriend uses a condom as seen below:

I want to, but my boyfriend does not want to. So he gives me no choice except for me to leave him.
So you don't want to leave him?
No, I don't want to leave him but I do want to condomise but I don't.

FGD, females, rural Eastern Cape

7.6 Family Planning Facilities

There was an overwhelming response as to the role of clinics in the area and the work that they did in providing family planning services. In many cases services offered at these clinics was said to be adequate but that more could be done especially for participants that live in rural settings who mentioned the services of the mobile clinic and that this assistance was not frequent enough.

In this community, is there a clinic?
Yes.
In that clinic, are they ever educating about family planning?
They teach them.
Do you think young people are using that programme?
Yes, because when you go to the clinic you find a queue of young women, for family planning.
Who goes for family planning?
Women.
Men don't care about it?
They don't care at all.
What are the services offered by that clinic?
They provide injections and condoms together with pills.

IDI, female, rural Limpopo

Though the above discussion paints a picture of men not wanting to participate in family planning, the following shows that some men, especially in the younger ages, could be good recipients of the family planning messages.

Condom is something that we use as men to protect ourselves from disease and pregnancy.
How does it prevent pregnancy?
Because what a man releases during sexual intercourse does not penetrate a woman but remains in the condom.
What is it, things you said does not penetrate?
Sperms, which cause conception if they have penetrated in a woman.

FGD, males, rural Limpopo

It was also mentioned that more information should be spread as to the existence of such services because people were sometimes ignorant of the whereabouts of such

services. It was however difficult to draw out exactly how people wanted information about such services to be spread, as exemplified by the flow of discussion below:

How can information about family planning be spread?
It is just that you have to talk to your friends that we should not give birth to children.
How can that be done? How can we discuss that with the whole community? Which way can we use?
Because you cannot have a boyfriend and not sleep with him. It is therefore better to plan, prevent so that you do not get a child.
How can many people know that so that they would not have children?
It means they can prevent.
How can we tell them that they must prevent? Which way can make everyone know how to prevent?
It means that would require a public meeting where this issue could be discussed so those in attendance can hear.

IDI, female, urban KwaZulu-Natal

There was also mention of increasing the number of community workers so that they can visit more homes and the community to talk to the youth. It can also be useful to educate the people through schools when the people were still young. The use of the radio was also mentioned as being an important means of passing information on family planning since many people have access to it.

7.7 Sources of Information on Sexual Matters

On parent-child discussions about family planning, many women were of the opinion that children should be taught about the methods and be given the choices, for example, a woman in Kwazulu-Natal said:

I am able to advise them, especially my daughter, that if she see a menstruation, she must tell me, so that I can take her to the clinic for family planning. The boy I will tell him to play away from the girls. I will look for a box of condoms, I will tell him that if he is in love he must condomise, I will tell him that I don't want to lose him.

IDI, female, rural KwaZulu-Natal

The discussions around sexual relationships revealed that parents rarely discussed sexual issues with their children, what they did was more "telling" them what they should not be doing. A lot of the discussions in the study revolved around how "bad" sexual relations among the young were; and how they should "behave" and wait for marriage the way the parents did. Statements by participating parents were of the form "one's children should not engage in sexual relationships before one is married or before one is 'grown

up' or before one's time is right". A similar finding was also observed in a recent study conducted in Lesotho (Mturi, 2003).

A lot of the discussions were geared towards advise that is given to girls and not so much towards the behaviour of boys, for example, "I warn them about that boys would not help you with anything …. you they will fall pregnant". Or "… if you open your legs and the boy penetrates you, which is disease and pregnancy". Boys were invariably described as "an enemy before your face".

The main thing that parents warned their children about was how the "mat led to HIV/AIDS". This was however not further probed by most facilitators as to what exactly was discussed about the disease and how parents were advising their children on the preventive side. Parents simply said that the disease was "dangerous" and that to avoid the disease one should not go to the mat. There was very limited mention of parents advising children to use ways to avoid getting infected such as using the condom (which only appeared a few times as a method of prevention of infection of STIs). The following is an example:

What is it that you discuss about sex?
We do not like it. We do not like my child, because it is no longer good. It kills. We tell children, we do not hide anything. We tell them that so and so died of it. We tell them sleeping with men causes AIDS. …. If you sacrifice yourself to sex, you will go; I tell them that those who have not slept with boys must stop where they are.

FGD, females, urban KwaZulu-Natal

Prescriptions against sexual relations by young people were also peppered with talk of "poverty" that early child bearing brings and also the responsibility of completing one's education. Virginity in its own right was a virtue to be preserved and children outside marriage were simply a way of increasing poverty at home.

I do warn children about sex, especially because of this disease. I advise them that there are still many things that are required from them because they are still studying. You must complete your standard ten first, …. When you start loving a person you must know whether you can start supporting yourself or not. It means I can get a child and feed him/her. If you are going to get a child without a work plan then who is going to support your child? It

means you can kill or do anything to that child. That is what I am trying to protect children from when I tell them that child, your time is coming. You must not do older people's thing.

IDI, female, urban KwaZulu-Natal

It was repeatedly mentioned that it was the responsibility of parents to educate their children to respect themselves and each others bodies; and to instil in their children the ability to say no when they did not want to engage in sexual relations. Some parents admitted not being able to talk to their children, voicing traditions dictating that someone else teaches the young about sexual issues and as: "It is almost a difficult thing because nobody taught me, I have to gather all my strength. So that I can guide them".

Children rarely raised sexual matters with their parents, as seen below:

Does it happen that you talk to your parents about sex?
Where can we start to talk about that?
We just talk among ourselves. I can't just say to my mother, did you see my girlfriend?

FGD, males, urban KwaZulu-Natal

Discussions between friends and older siblings revolved around "wanting desiring" a certain person to become their girlfriend/ boyfriend, or about a compatriot having so many girl/boyfriends. Boys and young men also discussed "how many times" they had sex and also "how they felt afterwards". Typical discussions were about bragging about one's prowess with girls; though there was mention of the potential dangers involved in sexual relationships.

7.8 Conclusion

This chapter has given examples of complexities surrounding issues of sexual behaviour and reproductive health issues, ranging from knowledge of sexual diseases, views on premarital sexual relations, knowledge of sexually transmitted diseases, family planning services and discussions on sexual matters.

There is an indication here that premarital sexual relations, though highly frowned upon by parents and the older generation, remain very common among young people. The knowledge of sexually transmitted infections is widespread though there are still considerable misconceptions especially about HIV/AIDS. The knowledge of the condom is also still shrouded in myths especially those to do with the origin of the HIV infections, and the powerlessness with which to demand that one is used is still a drawback in the fight against the epidemic.

It is indicated in the transcripts that discussions between parents and their children are still in the form of parents “telling” their children what not to do and dictating to them the consequences using “frightening” techniques. While advise on the use of family planning is available through the clinics, there is still room for improvement in the services of such facilities. For example participants mentioned that more information should be available through schools and be targeted at the youth. For those living in rural areas, such facilities could be made more accessible.

CHAPTER EIGHT

ACCESS TO HEALTH SERVICES

8.1 Introduction

The policies of exclusion of the pre-1994 government and the medical professions were such that large numbers of Africans did not have access to various services which under normal circumstances are provided either by the state or the private sector. The political, economic, social and cultural exclusion by the state together with the unwillingness or inability of the medical establishment to educate the public have had deleterious effects on, among other things, people's awareness of services provided by the state, access to the services themselves, the quality and perception of services as well as on the cost of services. The role of the state in such exclusion is presented by the *Health Expenditure Review (HER)*, which underscored geographic disparities and disproportionate spending on hospital-based care between 1992 and 1993 (McIntyre et al., 1995). The role of the medical establishment was evidenced by the steep cost-escalation in the private sector.

8.2 Awareness of Health Services

The *National Health Accounts* (NHA) project was a successor to HER and evaluated the success of the programmes that have been established by the post-1994 government to address some of the problems identified by HER. The NHA indicated that the lives of those reliant on the public health system have not improved very much between 1996 and 1999 in comparison with 1992/1993 (Thomas and Muirhead, 2000). Despite the efforts of the Department of Health in creating awareness of chronic diseases and their clinical management, our research suggests that we are a long way from the ideal situation of people possessing the awareness and ability to protect and treat themselves. For instance, it is clear from some of the respondents that they do not have sufficient information on diet and medication regarding

protecting themselves from various ailments. It is also clear that even if some of the people knew about diet and medication, the cost of these could render them out of reach.

Under normal circumstances, in order for people to be protected from illnesses which afflict their lives, they need to be aware of how they contract such illnesses, how to protect themselves from them, how to treat them, when to call on specialized assistance and how to use medication prescribed by the trained practitioners. If any or some of the above are not met, people contract preventable illnesses and either become incapacitated or succumb to such illnesses. These were some of the outcomes of exclusion.

8.3 Access to Health Services

The exclusion from access to services took various forms. Since the other forms of exclusion are discussed below, this section will limit itself to the absence of services and long distances to the services. By and large, medical services were either non-existent or few and far between for most people living in rural areas. The following are just a few examples from our research of how far people still are from clinics and hospitals;

There is no clinic nearer the community.

IDI, female, rural KwaZulu-Natal

There are no clinics, but there is a mobile clinic, it comes once per week. When we go to the clinic is a long distance and we pay R4.00, if you don't have money, you will walk very long distance.

IDI, young male, rural Limpopo

It is very far. It is around 9 kilometres from here to the clinic.

IDI, female, rural KwaZulu-Natal

… the clinic is very far other people walk on foot and they don't have money to get transport.

FGD, females, rural Limpopo

The non-existence or long distances to health facilities have created an environment in which basic health care knowledge is non-existent or minimal. Consequently people suffer from curable illnesses, with very little chance of relief.

8.4 Perceptions of Health Services

Over and above the distances travelled to the service sites, the perception of the services is influenced by the ease with which people access such services, by the relief from illnesses they get after visiting service sites as well by the treatment of patients by the staff at the service sites.

In order to meet the high demand for health services in rural areas, provincial governments have either built clinics or provided mobile clinics, which bring health services closer to rural communities. These services have been of some benefit to rural communities. However, because of the extreme backlogs, the services provided are overwhelmed by the need, thus affecting the perception of the service itself.

8.4.1 Benefits of Health Services

In order to meet the health care needs of a decentralized population, some provincial Departments of Health have embarked on a strategy to decentralise services by establishing clinics and, where this is still impossible, providing services through mobile clinics. The benefits of the availability of clinics and other health services are attested to by people interviewed in all provinces. The following are examples of people who benefit from family planning clinics. When asked about services in the area, an elderly woman from KwaZulu-Natal responded;

There is a mobile clinic that comes every first Wednesday of every month.

IDI, elderly female, rural KwaZulu-Natal

An old man from Limpopo responded;

Mobile clinics come during the week, but sometimes they take two weeks without coming.

FGD, elderly males, rural Limpopo

When asked about the types of services they get from family planning clinics, a young woman responded in the following manner;

They give you pills and injection.

IDI, young female, rural KwaZulu-Natal

An older woman responded in the following manner to a question, which sought to find whether the assistance people got from clinics was sufficient;

Yes it is sufficient.

IDI, old female, rural KwaZulu-Natal

Another woman who benefited from family planning clinics indicated that the clinic is fighting a losing battle against people who do not want to change their behaviour. When asked how information on reproductive health could be spread, she responded;

I do not know because people are stubborn, they do not want to listen.

IDI, old female, rural KwaZulu-Natal

Health services, even if they are through mobile clinics as seems to be the case in KwaZulu-Natal and Limpopo,[5] appear to be serving the interests of people who avail themselves of the services. From the responses provided, it is clear that people wanted to share many of the problems they experience when accessing health services. However, such services might not succeed if people either do not avail themselves of them or do not follow instructions.

8.4.2 Problems of Health Services

The benefits of the health facilities that have been brought close to where the people are is undone by various factors relating to the staffing of the clinics, attitude of staff, the stocking of medication, and the poor and shortage of resources provided for the health facilities.

- **Staffing**

The issue of staffing has long been a concern of health service recipients and researchers of health services. According to Lehmann and Sanders (2002), the South African National Assembly Portfolio Committee on Health has added its voice among those concerned with "DoH's deficient strategy on human resources".

[5]. None of the respondents from the Eastern Cape mentioned the existence of mobile clinics. Members of the Provincial Reference Groups have assured the team that mobile clinic service is part of the Eastern Cape provincial health provision strategy.

Regarding staffing, our research found that one of the main complaints was that the clinics are always full. A woman in KwaZulu-Natal who was asked about the difficulty of taking people to clinics responded;

It is a real problem because the clinic is always full.

FGD, young female, rural KwaZulu-Natal

Some of the reasons health facilities are always full are related to the fact that the service could be the only one for kilometres around and is also available only on certain days, as has been indicated above. The respondents indicated that the mobile family planning clinics were available once a month in KwaZulu-Natal, and about once in two-weeks in Limpopo. Also, because the clinic might be the only one for kilometres, some people come to it with ailments for which the clinic is not equipped.

- **Lack and shortage of medication**

Because public health facilities function on a walk-in basis, they often cannot anticipate the numbers of people who will avail themselves for the services each day. This, together with the lack and shortage of provisioning, leads to health services running out of essential medication. The following is an example from the Eastern Cape. When asked about the existence of clinics in her area, this woman responded;

Yes there is one but it is the same as non-existent because there are not medicines and it opens at 8 and by 2, time for people here in the township is over. They go for lunch and at 2:30, it is time for school children and as a school child you have to come in a school uniform and at 4 they close the clinic. If you go there without a school uniform, they tell you to go back and come the following day and when you go, they tell you they don't have medicines. If I go now and ask for cough medicine, they will say they don't have.

FGD, young female, rural Eastern Cape

In this case, it seems as though, in order to address the problem of large numbers, the clinic staff decided to deal with the elderly in the mornings and with school children in the afternoons. However, as the respondent indicates, this created other problems for elderly people. This could be caused by large numbers of the elderly

who need health services and the infrequent availability of the services. The permanent clinic in Zwelitsha is far enough away that the elderly need to take transportation to get there.

The issue of the shortage of medicines was mentioned by respondents from all the provinces. A woman from KwaZulu-Natal responded in the following manner;

It is just that I do not know how can we let clinic people to give us medicines for what we suffer from. Sometimes they tell you that there is nothing we can help you with. We have run out of stock both for injections and medicines.

IDI, elderly female, rural KwaZulu-Natal

Another KwaZulu-Natal woman who had taken a child all the way to the clinic found that the clinic did not have the necessary medication for her child. Asked if she was satisfied with the service she received from clinics, she responded;

Sometimes it is not helpful because if you take a coughing child to the clinic and ask for medicine, they tell you that they do not have it or give you pills.

IDI, elderly female, rural KwaZulu-Natal

The large demand for health services in rural areas and the non-provision or infrequent provision of such services is a cause for concern for the staff of such services as well as the recipients.

- **Shortage of beds**

The shortage of medication goes together with the shortage of other facilities such as beds for patients. An Eastern Cape woman who commented on the state of health facilities in the Eastern Cape said the following;

One of our problems in the health department, our hospitals are dying. As I am speaking to you, there are 28 beds in the whole hospital. The doctors who work there say the government doesn't do anything to help them so much that when the man took someone to hospital yesterday, he had to come back with that person because there were no beds. There are 14 beds for females and 14 for males. The person had to come back; they even said there were no pills. That is one of the problems we have here at Fort Beaufort because even the doctors that we have at the hospital are saying they are going to leave and open their surgeries. When they open their surgeries, we won't be able to go to them because we are not working.

FGD, females, rural Eastern Cape

Because of the shortage of hospitals, facilities meant to service out-patients end up taking-in patients when they are too ill to be returned home and are too far away from the nearest hospital.

- **Prescription of inappropriate medication**

Sometime, in order to get people through the queues, health workers give people whatever medication is available. The following are just a few cases of this experience;

There is a problem like having a headache and be given a medicine for stomachache.

IDI, elderly female, rural KwaZulu-Natal

A Limpopo man responded;

Clinic help but they don't help well, sometimes you find that if a person is sick, they say there is no medication, you must got to the hospital.

FGD, males, rural Limpopo

Asked of the assistance they receive from clinics, a woman in KwaZulu-Natal responded;

There is nothing. Others go to hospitals trying to get help but get told that 'we do not see the disease that you have, go home. They give you painkillers or never tell you what you have.

FGD, females, rural KwaZulu-Natal

In order to address the problem of staffing and of clinics being overwhelmed by patients, provinces have devised plans either to channel people to clinics that are nearest to where they are or to certain facilities which would carry the types of medication patients want. This policy, while understandable from a provisioning point of view, is confusing to the patients who need to get their medication from the nearest facility because they cannot afford transportation costs.

- **No medical advice**

Often the problem is more than just being given the wrong medication. Patients are often not told what they are suffering from, its causes and how to prevent it. As a

result, they suffer repeatedly from the same illnesses. The following are examples of people who said that they were not told what they suffered from. When asked whether she received help from clinics and hospitals, an Eastern Cape woman who suffered from cancer responded;

On the breast I got some help … Sometimes my womb gives me problems and the doctors don't quite give me the right medication.

FGD, females, rural Eastern Cape

The mother of an 11 year old said the following;

I have an 11 year old and last month the doctor said his heart was leaking. He is in standard 2 and I have not received any help. All he says is that his heart leaks.

FGD, females, rural Eastern Cape

It is often a complaint of patients who attend public health institutions that the medical staff do not provide appropriate medical advice to them. They are often not told what they are suffering from, how they contracted it and how they could protect themselves from it. When medication is prescribed, they are never told what it is and what it is for. All they hear is "Take these so many time a day after meals and come back to the clinic after ten days".

It is possible that the overcrowding at public clinics and hospitals is such that the staff have limited time with each patient. Such limited time may not be sufficient for the staff to provide all the essential medical information that patients require.

- **Problems with medication**

All medication has side effects. When such effects are identified, appropriate action can be taken to address them. However, because of the environment in which the patients and health workers interact in public health centres, the problem remains un-addressed. The following are just examples;

They say pills swells them while others say pills destroy their private parts. My child was using what is called 'loop' and it caused bladder-cancer and ended up passing away.

IDI, female, rural KwaZulu-Natal

One KwaZulu-Natal woman put the blame on the negligence of the health workers;

They do not check whether an injection is suitable for you or not. When you come for prevention, they ask you 'with what', with injection or tablets?' They do not examine which will be suitable for you.

IDI, female, rural KwaZulu-Natal

One of the nurses at a clinic said the following;

I usually observe that those children whom we are testing produce a liquid in their private part. When you ask her, she tells you that she is using an injection but it is not suitable for her. Another would say she is bleeding because of pills.

IDI, female, rural KwaZulu-Natal

An Eastern Cape woman who had a period every day for twelve months got limited relief from medication provided by a doctor. The story was relayed by her friend:

Washing every day, it ended up being a year. She tried to go to the doctor with that problem, to specialists to see what her problem was. There is a doctor who helped her but now its back.

FGD, females, rural Eastern Cape

Sometimes the problem is with the advice on the use of medications. Such failures tend to make some people think that the health facilities are not useful. The following are just two examples. When asked about the usefulness of family planning advice to young people, one woman responded;

There is no assistance because they end up giving more births.

IDI, elderly female, rural KwaZulu-Natal

A younger woman responded;

It is not enough because I got a child whilst using injection.

IDI, young female, rural KwaZulu-Natal

Many of the problems that patients complain about here have a lot of bearing on their awareness of the health of their bodies and how to keep themselves healthy. Some of the reasons medication may not be effective may not only be the poor quality of the medication and advise but also the ability of the patients to follow medical advice properly. All these together result in complaints regarding the quality of service patients get from public facilities.

- **Poor treatment of patients**

The issue of poor relations between health care workers and the public has been the focus of various studies in South Africa for some time now (Aubel *et al*, 1991 and Fonn *et al*, 1995). While the Fonn study relates specifically to the provision of family planning services, it underscores the general concern regarding the provision of health services.

The long queues, shortage of medication and poor training of staff takes its toll on the health workers. Consequently, their treatment of patients is less than admirable. The following are examples of such experiences;

They (nurses) are rude and talk whatever they like to talk. Some of them are not able to talk to a person.

IDI, female, rural KwaZulu-Natal

Another woman, when asked whether the assistance given by nurses was enough, responded;

It is not enough because if you go there sick they tell you to go to the hospital. They do not even call an ambulance. They tell you to go there with your own money, yet you do not have money to hire a car.

FGD, females, rural KwaZulu-Natal

A woman from Polokwane said;

Some are afraid of visiting the clinics because nurses insult them.

FGD, females, rural Limpopo

Fonn and Xaba (2001) have identified some of the contributing factors to the behaviour of health care providers. In most cases, the overcrowded environment, without sufficient facilities and medication in which the medical staff and patients interact is a potentially explosive environment. Some of the medical staff themselves may not have sufficient training to deal with the conditions they encounter in public facilities. Consequently, patients end up being subjected to various types of abuse. Without concomitant changes in resourcing clinics and hospitals (such as that

provided for in the Health Facilities Revitalisation Programme), it is difficult to envisage the success of the proposed Patients' Rights Charter.

- **Young people prevented from using family planning clinics**

It appears as though in order to bring down the numbers of people who come through their facilities, health workers dissuade young people from availing themselves for family planning services. The following are examples of this;

If we want condoms, they ask what are we going to do with condoms because we are young or they just say they are on lunch even if they are not.

FGD, young females, rural KwaZulu-Natal

If we arrive at the clinic, they shout at us such that you cannot even say what you want. This discourages you from going there another day.

FGD, young females, rural KwaZulu-Natal

It appears as though health workers are not the only ones who feel that young women should not avail themselves for family planning services. There appears to be some cultural reasons for preventing young people from attending medical facilities. The following are just examples of this;

I say children should not prevent. Children should be told about good behaviour because they say if you prevent whilst very young, your body loses shape.

FGD, females, rural KwaZulu-Natal

In some places, visiting a family planning clinic can result in a young girl being stigmatised as a loose woman;

Yes there are family planning clinics in this area, where people get injection or pills for contraception. When you are found there as a young woman, people do talk about you saying you are "planning" it must mean you have a boyfriend. I think parents must be told not to stop their children from going to such clinics because that is where they can be told the truth about how to protect themselves sexually.

IDI, young female, rural KZN

A young woman from Limpopo said;

The youth is not allowed (to use contraceptions), because the contraceptives makes a person to suffer when she want to have a baby. They can also makes a person not to have a child at all.

FGD, young females, rural Limpopo

The implications of prevention from accessing family planning services are such that some young women do not avail themselves of the services and prefer to expose themselves to pregnancy and worse rather than to face the disapproving adults. The following is one case;

One woman said;

I don't go. I am afraid, I must say that.

FGD, young females, rural KwaZulu-Natal

And another said

I don't go. I 'd rather eat a banana without its skin. (Meaning she would rather have sex without a condom)

FGD, young females, rural KwaZulu-Natal

- **Practitioners helpless against HIV/AIDS**

Over and above all the problems experienced by patients at the health facilities, what seems to make them despair is the inability of public health facilities and practitioners to either cure or mitigate the effects of HIV/AIDS. The following are just a few cases;

There is nothing except that since this disease arrived, it is destroying people … I do not believe so (that they get medical treatment) because they go to doctors and traditional healers and come back without help and pass away.

IDI, female, rural KwaZulu-Natal

It (medical treatment) does not help them because if it was helping them they would not be passing away in this manner.

IDI, female, rural KwaZulu-Natal

The doctors say nothing. They give him/her pills but don't make any difference. Sometimes you take him/her to the hospital, which, in turn, return him/her back home and suffer there until s/he dies.

FGD, females, rural KwaZulu-Natal

Let me say that as you are talking to me I have this disease but am alive and need to know how can I get help because in this area many people have this disease. If you go to the hospital having this disease they tell you to go back home because they cannot help you with anything. Maybe I am not yet sick but I know that I have it, so I

want help. They just tell you that you are not sick and give you painkillers only. I particularly want to know about the area where I am staying.

IDI, female, rural KwaZulu-Natal

The absence of a cure and the inability of clinics and hospitals to provide some relief with respect to HIV/AIDS leads to despair which leads to other problems as people search in vain for relief and a cure.

8.4.3 Benefits of Traditional Medicines

By and large, people in rural areas use two different forms of medicine; traditional medicine and allopathic medicine. While the study was not on traditional medicines *per se*, enough information was gathered to provide a picture of when and why people use traditional medicines. Some reported that they resort to traditional medicines when public health facilities chase them away. Some of these reported some successes. The following is a response from a woman from the Eastern Cape whose husband was given a short time to live, after being diagnosed with meningitis. When asked whether traditional medicines are helpful, she responded;

Wow! They are very helpful, I remember that my husband who is working in Port Elizabeth phoned to say he was not well, I travelled early in the morning, I found him almost finished and came home with him. Medical doctors could not help him. When he was given an African medicine, he resumed duties, whilst white doctors had said he was dying

FGD, adult females, rural Eastern Cape

Another example is from a woman who, when asked how people treat arthritis, respiratory failure and eyesight problems responded;

They buy Zulu traditional medicines during pension-pay days.

FGD, adult females, rural KwaZulu-Natal

A woman from Limpopo showed that even though there is a clinic in the area, people still use traditional medicines;

It (the clinic) helps sometimes but we also use medicines from a Venda tradition.

FGD, females, rural Limpopo

In general, rural people use both traditional and allopathic medicines. While allopathic medicine has proven that it is efficient at curing certain ailments, there are ailments which rural people believe can only be cured by traditional medicines. For instance, an Eastern Cape woman suffered for a long time before she was cured by people who recognized that she was being called by her ancestors;

They (doctors) said they don't see what could cause the fits so much that they did not even give me some treatment …about four of the traditional doctors said the same thing … they say I fit because I am
Being called by my ancestors, I should also become a traditional doctor. Four of them said the same thing … a man who initiated my grandmother, the ancestors told him to start with what I am doing now …
The red and white beads that I am supposed to wear. After that I will do the Xhosa things.
This is the Zulu way because my mother is Zulu.

IDI, female, rural Eastern Cape

8.5 Costs

The exclusion of Africans worked at all levels. They were not only excluded from accessing health facilities. The low wages which they were paid ensured that even when services were made available, many would still not be able to afford them. The location of their settlements in areas without infrastructural provision ensured that, even when services were rendered free of charge, many could not even get to the services or getting there would be prohibitively expensive. The expected benefits of cost-recovery in health care provision, such as those suggested by Akin et al. (1987) and Parker and Knippenberg (1991) are overshadowed by the difficulties experienced by poor people when accessing health services once service fees are charged.

8.5.1 Services

The following is a case of the cost of health services which is compounded by the irresponsibility of the siblings and their inability to control spending beyond their ability to pay;

This lady has a problem with her brothers. They like smoking and drinking and they have TB. There are 3 of them and they all have TB. One was admitted in hospital yesterday and he was just from hospital. The problem is that every time you got to hospital, you have to pay, it doesn't matter that you were recently in hospital … While this lady was taking the sick brother to hospital, the other one who is also sick came here to the house and we told him that his sister is in hospital, taking the other brother. We told him to leave the grocery money so that we give her when she came back and he saying he will come back. He did not come back until late and I told her that she is not going to get any money until she goes there to get it …Indeed, the money got finished and she

came to me saying I was right, there was no more money. This lady has a big problem that social workers can't solve.

FGD, females, rural Eastern Cape

It seems as though the woman's brothers take advantage of her. They get government sickness grants. However, instead of saving their money, they spend it all with the knowledge that she would bail them out when the need arises, such as when they have to pay for the hospital and medication.

8.5.2 Transport

The long distances that people have to travel to health facilities add to the health bill because people are forced to take transportation to get where the facilities are. The following are just a few examples;

Yes but it is a mobile clinic. It is up there at Matimatole and you take a ride if you go there.

IDI, female, rural KwaZulu-Natal

The hospitals are far from us. We use public transport in order to get to Greytown hospital or Maphumulo hospital. The hospitals are really far away from us.

IDI, female, rural KwaZulu-Natal

When we go to the clinic is a long distance and we pay R4.00, if you don't have money, you will walk very long distance.

FGD, young males, rural Limpopo

Asked whether there is a clinic that treats arthritis, one woman from Estcourt responded;

No, they go a hospital in Durban.

IDI, female, rural KwaZulu-Natal

The cost of transport can have impact on people's health. The following case suggests that some people postpone going to distant clinics and wait for the time when clinics are available nearby.

It is R2 on a bus and if you don't have, you walk or wait until they have medicines. If they say they will have them next week, you go then if it is not serious.

FGD, adult females, rural Eastern Cape

Nyonator and Kutzin (1999) refer to a system in which poor people continually fail to access health services due to fees, while their well-to-do counterparts have easy access, as 'sustainable inequity'. While government attempts at addressing past exclusion have gone some way in addressing this problem in South Africa, cost-recovery seems to be pushing back the tide of success.

8.6 Concluding Remarks

The exclusion of Africans from services provided by the state has led to the shortage of information on how to prevent illnesses and diseases and how to control them once one contracts them. The long distances to available facilities, the overcrowded facilities and the shortage of essential medicines colour people's image of the health services being provided to them. Despite the strides taken by provincial governments in addressing some of the backlogs in health provision, many people remain without proper access to health information, appropriate health facilities and funds to take themselves to services where services are too far from their places of residence.

With a better co-ordinated national health service provision, better funding for facilities, particularly to rural communities, and better resourcing (including staffing, management, equipment and medicines), health provision to rural communities should be better improved.

CHAPTER NINE

ILLNESS AND DEALTH

9.1 Introduction

Chapter eight argues that a causal link between the history of exclusion and the types of access to health services available to rural Africans exists. The lack of access to information as well as health services results in the types of illnesses from which people suffer as well as the illnesses from which they die. The services and information backlogs presented in both the *Health Expenditure Review (HER)* (McIntyre *et al*, 1995) and the *National Health Accounts Project* (NHA) (Thomas and Muirhead, 2000) indicate evidence to support the argument that the introduction of intervention policies during the transitional phase of many provincial government departments have had little effect. This chapter addresses the types of illnesses from which people suffer and from which they die. It also addresses the various ways and means to manage the illnesses, various methods of coping with illness and death as well as the manner in which funerals are conducted.

9.2 Age/Sex Differentials of Illness

Our research suggests that the causes of illness differ between the young and the old. While older people seem to suffer from preventable chronic illnesses, young people seem to suffer from sexually related illnesses. There are also illnesses that affect people of a particular gender.

9.2.1. Old people's illnesses

Day and Gray (2002) indicate that some of the illnesses that affect adults are hypertension and diabetes. This is confirmed by the findings in this qualitative study. Respondents reported that old people suffer from various illnesses including hypertension, sugar diabetes, arthritis, asthma, tuberculosis and eyesight problems. The following were responses to the question on common illnesses affecting the elderly;

High blood pressure, sugar diabetes and TB and arthritis. My bones are painful right now. The clinic gives us medicines for old people. They give you a date, for an example, yesterday when I went there they gave the date of the fifth and every month I get my medicines.

FGD, elderly females, rural Eastern Cape

It is arthritis, respiratory failure and eyesight problems.

FGD, elderly female, rural KwaZulu-Natal

But old people suffer from high blood pressure and sugar diseases.

IDI, old male, rural Limpopo

Although this fact does not appear in our research, it is notable that the elderly generally do not have sufficient information regarding how they develop the illnesses they have, how to ensure that they do not get worse and how to manage the illnesses. An example of this is hypertension, which should be manageable with proper medication and knowledge. But the numbers of elderly who die from hypertension and its complications suggests that they have insufficient information regarding how to manage the illness.

9.2.2.Young people's illnesses

Day and Gray (2002) also discuss illnesses that affect younger people more than adults. Among these are sexually transmitted diseases, tuberculosis, and HIV/AIDS. This information was confirmed by the respondents of the RA who also identified illnesses, which they felt tended to affect the young more than the elderly as TB, STDs and HIV/AIDS. The following are examples of answers to the question on illnesses affecting young people;

I can say that youth mainly suffer from diabetes and the youth suffer from HIV/AIDS

FGD, young females, rural Eastern Cape

The disease for young people is AIDS.

FGD, females, rural KwaZulu-Natal

These days there is drop and "tshofela" (could mean herpes) with *tshofela* you get sores on your private parts, they are not too big they are white. When you go to clinics or hospitals they give you pills, which do not heal it completely, traditional medicines heal them completely. Drop and the other disease (tshofela) are nearly the same because they all smell when the dirt comes out.

FGD, young females, rural Limpopo

While tuberculosis, diabetes and hypertension were also mentioned in relation to young people, in all three provinces sexually transmitted diseases and HIV/Aids were identified as the major illnesses from which young people suffer.

9.2.3. Women's illnesses

There were illnesses, which were identified as affecting only women. These included sexually transmitted infections as well as some that are a consequence of other illnesses such as diabetes. The following are examples;

I had a painful waist and I went to the doctor and I was given pills. He examined me and I got an injection and he gave me pills. After I had taken the pills, I felt so much better but not quite. A few days after I noticed that I had a discharge and I thought that maybe this discharge was caused by the waist problem. I got better and I went to the doctors again after I felt pain in the waist again and I saw that I had a lot of discharge and I thought that I could be dirty in the womb …

FGD, young females, rural Eastern Cape

Breast cancer is another common thing here in Sweet Waters. Sometimes you get pimples on your breast or get sores.

FGD, young females, rural Eastern Cape

9.2.4 Mental illness

In all three provinces a number of people indicated that mental illnesses were a concern in their communities. This information came out without solicitation. The following are examples of this;

Our children get mad for example my husband's child is in King Williams Town, she is mentally disturbed and she was working when she got sick.

FGD, females, rural Eastern Cape

His son once went to stay in Empilweni Hospital, a hospital for the mentally disturbed because from time to time, he loses his mind. He once beat up his mother because of the illness and his mother called the police.

FGD, females, rural Eastern Cape

The other prevalent disease in this area is mental illness.

IDI, female, rural KwaZulu-Natal

There is a clear pattern that rural communities have noticed. While older people tend to suffer from chronic illnesses such as hypertension and diabetes, younger people tend to suffer from sexually transmitted diseases. There are also illnesses that are affect women only and mental illness, which seems to affect the youth of rural communities.

9.3 Causes of Death

Some of the illnesses that people suffer from eventually result in death. Our research suggests that, as is generally the case with illnesses, the causes of death differ between the young and the old. While older people seem to die from preventable chronic illnesses, young people seem to die from sexually related illnesses. The following are a few examples;

Every weekend there is a burial … even tomorrow there is a burial, it is this AIDS

FDG, young females, rural Eastern Cape

I would say the number one killer is AIDS. In some homes people hide it and some disclose in funerals and in others it is not disclosed. The mothers would say "No you will go about ridiculing my child". They will say the child was suffering from another disease though symptoms were showing. Perhaps the child was disclosing in celebrations or when they were encouraged not to give up, the person would stand up and disclose in the absence of the parent and the parent won't know if I am HIV positive.

FGD, young females, rural Eastern Cape

Yes, like AIDS, which affects mostly young people

IDI, female, rural KwaZulu-Natal

There is this disease they call AIDS that is finishing our children, I'm telling you we won't have grandchildren.

FGD, females, rural Limpopo

I can't talk about in-laws because a son of my husband's sister died of it, another sister in-law is infected. She talks about it and does not hide it. My husband's younger brother has died of it and now there are 4 in the in-laws who have died of it.

IDI, adult female, rural Eastern Cape

By and large, according to respondents, young people die from HIV/AIDS. This was the feeling in all the provinces, even though people from the Eastern Cape seemed to mention it more than people from the other two provinces. However, while most

people identified HIV/AIDS with young people, it was clear that young people were not the only ones dying of the disease. The following is just one example;

As a matter of fact we were burying my sister in law on Saturday. She died of AIDS. AIDS and TB here in Emnyameni are overpowering us.

FGD, adult females, rural Eastern Cape

Tuberculosis and respiratory failure are also some of the illnesses, which are claiming lives in all three provinces. The following is one example of someone from the KwaZulu-Natal and the Eastern Cape;

It is tuberculosis and respiratory failure.

FGD, adult females, rural KwaZulu-Natal

The TB sufferers go to SANTA and are admitted. They don't want to stay at SANTA but decide that rather than staying for six months at SANTA he prefers clinics but they default in taking the treatment.

FGD, females, rural Eastern Cape

Since tuberculosis and respiratory failure are related to HIV/AIDS, it is possible that the cause could have been HIV/AIDS.

9.3.1 Provincial differences in causes of death

There are notable differences in the provinces with respect to some causes of death. Limpopo was the only one in which people mentioned road accidents as a major concern. The following are examples;

Most deaths in our area are a result of accidents, yesterday we went to a funeral where the person died of a car accident. Others are mostly caused by diseases while others are natural deaths.

IDI, female, rural Limpopo

These unending diseases and car accidents and most of the time if a person is hit by a car I'ts rare that they'll live.

IDI, female, rural Limpopo

Deaths are caused by different things, you see diseases and accidents are the things that causes deaths here.

IDI, female, rural Limpopo

The Eastern Cape and Limpopo are the two provinces where people expressed concern regarding crime, violence and suicide as causes of death. However, there were more examples of this from the Eastern Cape. The following is an example;

People stab each other. They are people called Madamara here … Other people die of AIDS, others of being stabbed or shot, some kill themselves.

FGD, young males, rural Eastern Cape

KwaZulu-Natal is the only province where malaria, fever, cholera and faction fights were indicated as causes of death. The following are examples;

There are many people who die because of malaria fever.

FGD, females, rural KwaZulu-Natal

Young people are dying at a faster rate then older people in our area and grandparent no longer enjoy their pensions because their money is put to work supporting all these grand children. One of the big diseases in this area is cholera caused by unclean water.

IDI, female, rural KwaZulu-Natal

The major cause of death in this area is faction fights which kill men, but women just die of natural causes.

IDI, female, rural KwaZulu-Natal

But young people also kill each other in faction fights so that it is people between the ages of 18 to about 30 that die.

IDI, female, rural KwaZulu-Natal

Some people identified witchcraft among the major causes of death in their communities. The following are examples;

I think it is cancer and AIDS and stabbing and witches (that are the main causes of death) … I said witches. When a person hates you, they say I will show you on a certain date and when that date comes, just like that woman who is being buried …They were fighting over a do with her neighbour, which went inside the garden and the neighbour said I will show you! And she got sick and we heard that she passed away.

FGD, young female, rural Eastern Cape

What can I say? The common thing here is 'witchcraft' (*idliso*). A person gets sick today and the following day you do not understand his/her illness. S/he did not even go to the special doctor to find out his/her problem. The problem is most people get sick and die 'same time'. It means they bewitch each other in most of the time?

IDI, female, rural KwaZulu-Natal

There are various causes of death in all provinces. The clear patterns are that older people die of chronic illnesses while young people die mostly of sexually transmitted diseases. There are also provincial differences which are characterized by deaths due to criminal violence in the Eastern Cape, road accidents in Limpopo and malaria and faction fights in KwaZulu-Natal. All three provinces expressed concern regarding deaths through witchcraft.

9.4 Management of Illness

When they are afflicted by illnesses, people employ various ways of managing the illnesses. They either go to clinics and hospitals or to traditional healers. For the most part, it appears as though most people go to either clinics or hospitals when they have afflictions;

Yes there is a clinic where you go get treatment when you have cancer or TB but people don't take their treatments properly.

IDI, female, rural Eastern Cape

They take them (sick people) to the clinic.

FGD, females, rural KwaZulu-Natal

By and large, rural people use both traditional medicines and allopathic medicines. They seem to know when to go to clinics and hospitals and when to go to traditional healers. Some either prefer to go to traditional healers or go there when they have nowhere else to go. The following are examples of some of this;

Others are taken to traditional healers and those who suffer from AIDS are given "bottles" that are said to be helping. The community health workers also help visit and wash them.

IDI, female, rural KwaZulu-Natal

They (sick elderly people) buy Zulu traditional medicines during pension pay days.

FGD, females, rural KwaZulu-Natal

Reasons for using traditional medicines include the fact that allopathic medicines seem not to produce the desired results and that there are illnesses which allopathic medicine cannot cure.

These days there is drop and *tshofela* (could mean herpes) with "tshofela" you get sores on your private parts, they are not too big they are white. When you go to clinics or hospitals they give you pills, which do not heal it completely, traditional medicines heal them completely.

FGD, young females, rural Limpopo

There are two main ways of managing illness. People either go to clinics and hospitals or they go to traditional healers.

9.5 Coping with Illness and Death

Culturally, when a person is ill, those around show support for the sick person and provide comfort to the members of his/her family. While the community can provide emotional and other support, poverty is such that people cannot provide the kind of financial support they would like to provide. In such cases, some people rely on government grants for survival. However, as will be shown later, government grants present people with other challenges.

9.5.1 Support groups

For the most part, communities seem to support people suffering from HIV/AIDS. Some communities have even formed support groups. The following are examples;

Yes there are such (support) groups … They come to counsel but things like where we can get pills and help, we don't get from them and they also don't know because they don't come with helpful things like first aid things or tell us that if a person gets sick, this is what we must do. All they do is come in and out of peoples homes and you will not really know what they do except to counsel these HIV positive people.

FGD, females, rural Eastern Cape

There are groups formed which go house to house explaining about the Aids and the way you can live while with Aids.

IDI, female, rural Limpopo

There are community-health workers who visit sick people in order to help and wash them.

IDI, woman, rural KwaZulu-Natal

9.5.2. No support

In some communities, however, HIV/AIDS sufferers and their families are on their own. The following are just two examples;

Above all, my sister does not have pension and she stays with these children at home and nobody works. There are seven all of them and some of them go to school, one will graduate next month and another

is also sick and does not work, s/he is HIV positive, then there are two children who depend on my sister who does not have the pension grant, she depends on this money for these boys.

FGD, females, rural Eastern Cape

If I am sick at this home, that is a problem for my family and me. The community helps me with nothing.

IDI, female, rural KwaZulu-Natal

9.5.3 Government grants

Often when illness strikes, the family struggles to find additional resources to procure medicines for the ill member as well as support the other members. In rural communities, where remittances have declined due to unemployment, people survive on the various government grants. Some of the difficulties with government grants is that it takes time to get it after applying and, sometime, it gets cancelled without notification. The following are just a few of the cases;

Their mother came to stay with me after my father died. The father of the children is sick and all of us depend on the pension grant. I tried to get a grant from the doctor because I don't work and I am sick. I applied in 2001, 2002, and again in 2003. Right now I am from hospital and as you see me I was trying to work but I can't because my bones are painful. I have a child who is not well. She has a virus since last year but the doctor did not tell me.

IDI, young female, rural Eastern Cape

What is helping now are these children who get the 'child support grant'.

IDI, female, rural KwaZulu-Natal

This child is very sick and if I hear that she has died, I wouldn't be surprised. If this grant comes before she is buried, she will not get it, they will say they cannot get it, I don't know how that works, that is very common here. I think 70% of the people here live that way; their pensions and grants come and go back.

FGD, females, rural Eastern Cape

Those who have TB, if you are fortunate the government gives you (disability grant) but most of them are not receiving, it is just a few who are receiving.

IDI, female, rural KwaZulu-Natal

My problem is that I have a child who is on TB treatment and at home I don't have a husband. I have two children. My problem is that I don't get any grant and I have two children. One is sick and also does not get the grant just like me. I have applied for the grant and it came back rejecting me. I once received the grant and this is the fifth year since it stopped. I applied again after they rejected me and I haven't received any reply. The other child is at home and does not work, she is sleeping now at home, she cant get a job. That is my problem. We survive by the grant money.

FGD, females, rural Eastern Cape

The conditions are so dire in some rural communities that people consider themselves fortunate to either have young children or to have a form of disability for which they can get a government grant.

9.6 Burials and Funerals

When the ill person eventually dies, the neighbours assist the bereaved family in various ways. Since, culturally, the bereaved family is not supposed to cook, neighbours and relatives bring food to the bereaved family until the day of the funeral, which culturally used to occur the day after the death. It is only after the day of the funeral that the bereaved family is expected to cook its own food. However, poverty and urbanisation have slowly but surely eaten away at such practices to such an extent that presently the bereaved family are the ones who are expected to cook for those coming to "comfort" them.

9.6.1. Costs

Among some of the costs they have to incur are the costs of keeping the body at the mortuary until the weekend, the preferred days during which funerals are held (mostly to accommodate distant relatives and friends), the cost of the coffin, buses to take mourners to and from the cemetery and either a goat or cow which is slaughtered both to ceremonially separate the dead with the living and to introduce the dead to the ancestors. The costs of such activities and functions are often beyond the reach of ordinary families. Booysen *et al* (2002) found that the median cost of funerals among the households of communities affected by HIV/AIDS in Welkom and Qwaqwa in the Free State Province was between R4000 and R5000 in mid 2001 and between R3000 and R4000 in late 2001. In some such communities, as was the case with the ones visited in our study, most people do not have, or cannot afford, insurance policies. In such communities, the invention of burial societies was, in one way, a measure aimed at assisting the bereaved family to cope with unexpected costs imposed on them by the death of one of their members. Domingues (2002) found that burial societies and church organizations were two of the means that poor people used to get out of poverty. This chapter is on the role of these societies in assisting people carry the burden of funeral costs.

Since contributions to burial societies depend on employment, the effects on unemployment, particularly in rural areas, are such that many families are not able to keep up with contributions. When there is a death, such families have very little on which to rely. The funeral is normally an experience where cultural symbolism and expression get shared among those present at the funeral. However, poverty and the seemingly rising rate at which people have to be buried, have presented formidable challenges to the manner in which people assist one another and the manner in which funerals are conducted.

9.6.2 Community help

For the most part, neighbours still help in whatever way they can to ensure that the departed are buried properly. Such help includes money donations, contributing food towards the funeral, contributing labour (women help around the household and men help with digging the grave and burying the departed). The following are a few examples of how people help;

> If you do not have the ability to take the person out of the mortuary, they (neighbours) are able to support you so you can take your 'bone' (corpse) and rest them at home.
>
> **IDI, female, rural KwaZulu-Natal**

> We help each other by contributing the little money we have but the start is R10.
>
> **IDI, elderly male, rural Limpopo**

> If there is somebody who passed away, they reap mealies and pumpkins from the fields and take it to the bereaved family.
>
> **IDI, female, rural KwaZulu-Natal**

> Due to prevailing poverty, it is difficult (to make provisions for a funeral) but people struggle and contribute something.
>
> **IDI, female, rural KwaZulu-Natal**

9.6.3 Poverty and inability to help

However, because of poverty and related problems, some people have moved away from the culture of assisting one another in times of death. The following are just two examples;

People have changed. It is not like in the past. They are no longer helping with anything.

IDI, female, rural KwaZulu-Natal

If you have a society that is the thing that will bury you, we are poor we can't bury you.

IDI, female, rural Limpopo

There is nothing (that the community does) because my dead person becomes my responsibility.

IDI, female, rural KwaZulu-Natal

9.6.4 Burial societies

In order to ensure that they were not left without means to bury their loved ones, many families joined burial societies. Some of the functions of burial societies are enumerated below;

There is a burial society that collects money from people every month in this area. If you have joined it, it becomes easy to bear funeral expenses.

IDI, female, rural KwaZulu-Natal

There are burial societies; they help with cattle and moneys so that they can buy coffins.

FGD, males, rural Limpopo

When there is death, we have a *Masiphilisane* (let us live together, help each other) and people get helped that way.

IDI, female, rural Eastern Cape

For those without burial societies, the situation gets very difficult. The following are a few examples of this;

There are those people who do not have them because people do not have equal power. You cannot have burial society if you are not working.

FGD, females, rural KwaZulu-Natal

It (the status of your funeral) depends on the burial society that the deceased belonged to because you must also contribute some five cents (save) and prepare yourself for an unknown time. If you had been doing that, it is not the same because you can try. If you had not joined, what do you do? It becomes very bad but people collect money so that you could be buried.

IDI, female, rural KwaZulu-Natal

That is the problem because people cannot afford the mortuary, a person can die today and the following day is buried, because they don't have money to pay the mortuary

IDI, female, rural Limpopo

If you do not have a burial society, you are out. You are folded with a mat or a blanket and buried.

IDI, female, rural KwaZulu-Natal

9.6.5 Poverty and change of burial societies

The addition of HIV/AIDS on top of hypertension, diabetes, malaria fever, road accidents as well as crime and violence has resulted in many communities having to bury people within a short period. The following examples of this;

Many families are able (to bury their dead) but not that well because you find that a person pass away this month and another will pass away next month.

IDI, female, urban KwaZulu-Natal

If there is no money for doing that (making preparations for a proper funeral), I am buried the following morning.

IDI, female, rural KwaZulu-Natal

If the person is poor s/he could be buried on the following day.

IDI, female, rural KwaZulu-Natal

If I die now, people will try to get a car to take me to the mortuary and keep me there until the day of my funeral. If there is no money for doing that, I am buried the following morning.

IDI, female, rural KwaZulu-Natal

Poverty has changed the manner in which people conduct funerals. While many people have got accustomed to weekend funerals and the expenses that are incurred during a funeral, some cannot afford the expenses. In fact the inability to provide for the mourners is seen as a failure of some sought;

Others are very poor. They just bury a person and nothing happens on that day. People just leave after the funeral.

FGD, females, rural KwaZulu-Natal

9.6.6 Lack of government assistance

While in all provinces people indicated that they do not get any assistance from the government regarding catering for the funerals, some in KwaZulu-Natal indicated that traditional leaders do help in some ways, even if only by making announcements,

If a person dies now and things going well, the person is taken to the mortuary. But if people see that things will not be alright, the *inkosi* makes an announcement so that the person is buried on the same or following day.

IDI, female, rural KwaZulu-Natal

If a person has died, that is reported to *induna* who then makes an announcement about the date of the funeral. A grave is dug inside your premises. We do not pay for tombs. It is the bereaved family that knows what to do with the funeral. If they have a burial society, it helps them.

IDI, female, rural KwaZulu-Natal

One respondent reported that a councillor of her area helps when he can;

Let me say our councillor helps us at 1 if there is no one who is employed at home, there is no one who has money. If somebody has passed away, you go to report (to the councillor) that so and so has passed away and the family is poor and has nothing. The councillor is able to arrange the funeral with you. Perhaps another neighbour comes with food and another one gives you food. Perhaps you find that the donation money helps them to buy things that are needs for the funeral because you know modern children want custard and jelly. They do not care whether you are poor or not.

IDI, female, urban KwaZulu-Natal

The manner in which funerals used to be carried out has changed drastically. The influence of urbanization has resulted in people opting for expensive funerals and procedures. However, the poverty of rural areas has not only changed the ability of people to afford funeral expenses, it has changed their ability to help their neighbours during the time of bereavement. To a certain extent burial societies help to ensure that people can afford funeral costs. However, unemployment together with the rise in the number of burials per week are threatening to bankrupt many burial societies.

9.7 Concluding Remarks

From all indications, it seems as though knowledge about illnesses, how they are acquired, how to protect oneself from them, how to treat them and how they are cured is severely lacking in many rural communities. The acknowledged efforts through 'health awareness campaigns' appear to have passed these communities by.

There is also a concern that in some of such communities, for whatever reason, many people seem to have reached a point of reckless disregard for their own health and lives as well as those of others. This is indicated by, amongst other things, people who repeatedly contract TB, get treated for it, and do not finish the course of their medication as well as people who receive some form of government grant but, instead of using it to procure food and medicine, use it to buy alcohol, thus leaving themselves and their dependents without the basic necessities. This development is likely to be used to undermine the benefits of the proposed 'citizens or universal

grant'. In the era of HIV/AIDS, this development is a significant challenge to the efforts to arrest the spread of HIV/AIDS and to limit the number of lives lost through it.

It seems as though some intervention is necessary to turn around the entrenched imperative that people have to spend their life-time savings only to provide a funeral for one of their members. Most of the money is spent on non-essential frills such as the cost of keeping the body at the mortuary for a week or so, the cost of the coffin, the cost of food and even the cost of renting buses which take people to and from the cemetery. A lot of this unnecessary expenditure seems to be justified as part of tradition. But one does not have to think very far into the past to imagine how all of this could have been done.

The collapse of many burial societies which had been established to ensure that people had "proper funerals" is likely to impose a re-think of the meaning of a "proper funeral" for many. However, the well-to-do will continue to flaunt their wealth at funerals – for this is what it is really about. And as is the case in most societies, the poor will spend themselves into debt trying to emulate the well-to-do.

CHAPTER TEN

CARE AND SUPPORT

10.1 Introduction

One of the issues discussed during interviews was about the kind of assistance that families in need receive from their family members, the community members or the government. The actual question asked was, “What kind of assistance do families get from their members; how does the community assist; does the government do anything to assist such families?” In most cases respondents mentioned what they experience whilst in other cases it was about other people whom they know.

10.2 Household and Family Support

Participants were asked about any kind of support that they receive from their household/family members. Most respondents from across the three provinces mentioned that they do get support from their family members especially when it comes to finances. Most of them indicated that there are many children staying on their own in some households because their parents have either passed away, deserted them or have moved to other places to look for work. These households do not have an adult member who works but some have relatives who help them at times. However, the role played by the extended family in providing assistance in the bringing up of children did not come out clearly during the interviews: it appears that relatives are distancing themselves from such responsibilities.

It was mentioned that some of those who still have parents or working siblings receive financial support if those parents are responsible enough. However, there are those who do not have any adult member who works and provides them with whatever they need. Fortunately some of those children receive grants from the government so that the money can be used to buy food and pay school fees. But it is difficult for others

since they cannot get those grants if they have not registered and some are forced to do whatever they see fit to get money. These are some of the statements given by respondents.

My brother is getting paid on the 15th and brings that money, my sister gets paid by month end and on the 25th there is money that my mother gets because there was a father who was working but he died.

IDI, female, rural Eastern Cape

In our family we live better, my brother maintains us and my mother gets pension fund.

FGD, young females, rural Limpopo

These ones their mother left for work. They survive through their mother sending money through other people and buy food for them. Those who have no one to help survive through neighbours.

FGD, females, rural KwaZulu-Natal

If between those children there is a girl who is grown up, she will go and sleep around and bring the little money to support the siblings.

IDI, females, urban Limpopo

Participants indicated that there are other households where children are taken care of by their grand parents. Some of the reasons leading to this situation included on one hand mothers leaving the children and never coming back home so they end up being the responsibility of the grandparents. On the other hand there are those mothers who have children out of wedlock and when they marry a different man they leave children behind. If the grandparent has a pension then it is used to support those grandchildren but in most cases the money is too little to cover all expenses. The following reflect some of the responses.

Most grandparents are earning pension. Their earning does not help with anything because food is expensive; they always take food on credit. In addition schools are expensive for those children doing upper classes. If the grandmother has provided money for school, she does not have money for the doctor and clothes. The money is too little and cannot cover everything.

IDI, female, rural Limpopo

The children of my neighbour have a grandfather and their father works in hospital but he does not have time for them. It is even difficult to buy food for them, it is better because the grandfather gets pension and they go to his house to eat and go back home to sleep.

FGD, females, rural Eastern Cape

I also brought up my grandchildren because their mother did not work. Even now I take them to school, their father ran away and the mother is here but she does not stay here. The children stay with me because she can't get a job and she is staying with that man. But sometimes she gives me something, she looks for piece jobs.

IDI, elderly female, rural Eastern Cape

I think people are irresponsible because the pension fund cannot support the family and it's obvious the money is insufficient. The grand parents' money is misused.

IDI, male, rural Limpopo

The grandmother is earning pension, which helps with nothing because there are many children at home. She cannot buy anything for herself due to those children.

FGD, females, urban KwaZulu-Natal

Ardington and Lund (1995) confirms the above statements by reporting that "there is an important distributional aspect of pensions especially for the elderly and the disabled. That is they are awarded to individuals but are to a large extent consumed by the household, especially where the elderly live in three-generational families."

At times people run single-parent households because they are not married, they got divorced or they have lost their partners. In that case one partner becomes responsible for taking care of the children. The most common case mentioned was where females stay with children and that becomes a female-headed household. Households with males only raising children were also mentioned but they are not common. It was mentioned that some of them could afford to support the children because they are working but others cannot due to lack of employment. In order to survive, women go and work in the fields for some few Rand and others try to sell things in the market place but it's very difficult because they don't make that much.

The mother goes to look for temporary jobs because the time is bad or work in people's fields. Then they give her some beans to eat with her children when it is reaping time.

FGD, females, rural KwaZulu-Natal

Sometimes, families that have fathers are virtually similar to those that have mothers because you find that the father does not support children. Perhaps he lives in Johannesburg with another woman and these children are supported by their mother.

IDI, female, rural Limpopo

This indicates that it is not usually the case that households with fathers are better than those without fathers. It all depends on how responsible that father is in that household because some of them struggle even though they have fathers. Preston-Whyte (1993) reported that the composition of female-linked households is flexible,

arising in response to modern African marriage crises and the need for the care of children born out of wedlock. On one hand children are left with their grandmothers while their mothers go out to seek employment. On the other the mothers may be taken up with a new lover, who offers them prospects of marriage or long-term support, and usually returns when she can or must.

10.3 Community Support

According to Bhengu (2001) an enormous challenge facing siblings and the elderly is that they are living without income. Children depend on community-based and church organizations for survival. Volunteer workers, mostly unemployed also often use their own money to buy food for the children.

However, the evidence above did not come out clearly during the interviews. When asked about the support provided by the community to households that struggle to survive, respondents indicated somewhat mixed feelings with regard to this issue. Some of the respondents mentioned that they don't see anything that the community is doing to help in such situations because everybody is poor and families have to strive on their own. However it was mentioned that the village headman could assist only if such cases get reported to them and they try to inform the local social workers. They indicated that it is better for the households that have grandparents because at least they survive on the pension money. Some of the respondents said that:

Regarding help, people were helping each other in the past but now there is no co-operation due to poverty.
IDI, male, rural KwaZulu-Natal

We are trying but because of poverty we cannot help them, some days we share the food with them
FGD, young females, rural Limpopo

However, the majority of people across both provinces indicated that real assistance comes either from relatives or neighbours because the community usually does not know what is going on in that family, it is neighbours who know the problem. They indicated that some neighbours and relatives are able to share food and donate clothes if possible but in most cases it is very difficult because those who assist also

have their own problems so their attempts are limited. The following excepts reflect the picture.

The child-headed families I know are really struggling because not even one of them is working. They even go out to beg and get help from neighbours and us. We also give them worn out clothes".

IDI, female, rural KwaZulu-Natal

There is a family with children only, their parents died. At school they eat, the school buys vegetables and gives them. When they go back home they have nothing to eat, we have to see as neighbours that those people have something to eat. Here we help each other in whatever we have. As you saw them here, they came to ask for something to eat, that is how they live in that home.

IDI, female, rural Eastern Cape

Yes, there is a family like that one. There is a girl next door who is left with her son, they don't have jobs. There are no parents, they died. She was married but her husband died. I am her neighbour, if she wants something to eat I give her.

FGD, adult females, rural Eastern Cape

I've got such children next door, it is a lady and her brother and they are not working. The house they are living in was left by their parents. They make their own plans in order to eat. Their parents don't send any money for them, they suffer a lot. Sometimes they ask from neighbours.

FGD, females, rural Eastern Cape

As a community we are unable to offer help to such families because we are also poor. But we do support each other through the societies, when there is death we always help, neighbours share food and parents usually ask the neighbours to keep an eye on the household and the children while they are gone."

IDI, females, urban Limpopo

Yes they help because whenever we run out of sugar, salt and other things if they are able to help us they do so.

FGD, males, rural Limpopo

Some of those in urban areas indicated that there is lack of support from their communities. This shows that most of the people in urban areas do not have much community spirit, they follow the saying, "everyone for himself". For instance they said:

According to me there is no working together. The reason is that this is a location and most of us don't know each other, unlike in rural areas if something happens is for the community, in the locations I don't see support.

FGD, young males, urban Limpopo

Basically it is common across the three provinces that neighbours and relatives are the ones who usually offer help in the community but that happens mostly in rural areas. Interestingly other respondents reported that they offer assistance in the form

of advising each other to consult social workers to get help. In other areas it was mentioned that the civic associations do assist in identifying households that have problems and then report them to the social workers. Here are some of their responses.

We don't have money to assist them. We assist by asking them to attend workshops so that they can know about opportunities for work. We also tell them to visit home government offices to report that they are orphans. Government assist by providing pension fund to grandparents and also assist with children grants.

FGD, males, urban KwaZulu-Natal

Yes, we advice each other in whatever way we can and it helps. Sometimes the chief visits together with the leaders of the civic to see if others need food, they assist by telling the government about those in need in their community.

FGD, females, rural Limpopo

Yes these types of families we help them with advices or we give them old clothes and food. We take them to social workers, the families are sometimes helped by organizations like Red Cross or NCAW. We give them food, clothes and advices on how life is so that they must not feel lonely because their parents have died.

IDI, male, rural Limpopo

According to the International HIV/AIDS Alliance (2002) little is known about how well communities are coping and even less has been documented about the effectiveness of community mobilization approaches that should be scaled up to benefit children and families. In East and Southern Africa community based organizations and non-governmental organizations play an important role in meeting the needs of vulnerable children. However, the bulk of support to extended families caring for orphaned and vulnerable children (OVC) is provided through informal day-to-day activities from community members though little is known about them. Basically community OVC initiatives tend to be voluntary and desire to care for children.

10.4 Government Support

The government of South Africa provides assistance to its citizens in the form of grants or financial award and this is referred to as Social Assistance. The social assistance is provided in the form of an old age pensions – R700; disability grant – R700; war veterans grant – R718; care dependency grant – R700; foster child grant; child support grant – R500; grant in aid – R150 and social relief of distress. Grants are applied for at the Welfare offices and an important factor considered when

applying is the financial position at the time of application. The income and assets of the applicant and spouse or the concerned foster child are assessed. If the grant is approved then the applicant will be paid from the day of application and if unsuccessful, reasons for the refusal of the grant must be provided to the applicant in writing. Grants might be suspended as a result of change in circumstances, outcome of review or failure to co-operate when a grant is reviewed but it can be restored within 90 days of suspension. There are also reasons for the lapsing of a grant, namely death; admission to a state institution; if the grant is not claimed for three consecutive months; when a period of temporary disability has lapsed or due to absence from the republic for a continuous period of longer then six months (Department of Social Development, 2003).

When it comes to government support it was interesting to see during the interviews that many people across the three provinces acknowledge the help that the government is providing in terms of child support and pension as well as food parcels. It appears that for most people, these government grants are their only source of support so they really acknowledge this even though they complained that the money is too little. The following are some of the statements that reflect the extent to which people appreciate the efforts that government is putting into trying to help them survive. The two most common grants mentioned were old age pension and child support grant. The following excerpts provide evidence.

There is a lot of change because government is now able to give pension to elder people so that they can support themselves even though it's too little to cover all household needs. Young people, those who have children, are now also able to get some few cents".

IDI, female, rural KwaZulu-Natal

The government assists by giving people grants, the little one receive a grant and the father maintains the first-born.

IDI, female, urban Limpopo

The government helps us by giving us grants. It helps poor people by giving them grocery.

FGD, males, rural Limpopo

He is not working, what is happening is this 5 year old child receives a grant, therefore, they depend on this grant. Even this father depends on this grant. He usually gets groceries from the social workers.

FGD, females, rural Eastern Cape

According to Case and Angus (1996) improvements in the Social Security System has been reported to increase reliance on the elderly in South Africa. While Kinsella and Ferreira (1997) reported that there is growing public recognition of the importance of the pension system as a social safety net.

A few of the participants complained that they either did not know about support that government is providing or they were not well informed about some of the issues. They reported that they only hear these issues being discussed on radio but they have not really experienced it in their respective areas. This may indicate that, for whatever reason, information about government support does not reach all the people as expected. For instance one respondent said,

I once heard that children are supported but I have not seen it happening in our area.

IDI, female, rural Eastern Cape

Besides the above shortcomings, some of the people appeared to have a clear idea of what the grants are all about, for instance one respondent said,

There is something that the government is doing because in the last community meeting that we attended, a boy said that there is a family that he visited and found children living alone in surprisingly poor circumstances. He reported their situation to the chief who then reported the matter to the welfare department. The department brought them food and assisted them to register for an orphanage grant.

IDI, female, rural KwaZulu-Natal

Government is providing food parcels to those households that are identified as poor. However, there were complaints from some participants with regard to receiving these food parcels. A problem that was reported was that households register to get food parcels from social workers. However, some respondents mentioned that they do get those food parcels while others complained that they were receiving those parcels but suddenly they stopped and they were not told the reason for this, whereas some have never received them at all. The following are examples of what people had to say.

We were told to apply for the groceries and when we did that, they told us that they were only talking about those people who applied for pension and have not yet received it. They refused to help us. We won't really say the government is doing nothing to help us; most of the things here in our area have their people. For example if those people were told to feed pensioners, only three or four pensioners will get some help and you don't know what happened to the rest. Even after they have said maybe the contract is for two years, we will get food for two years, it will just be three months and after that you won't get that food anymore and we don't know what happens to it.

FGD, females, rural Eastern Cape

No, the government does not help, we don't see anything they do even the maize we were supposed to get it is not provided.

FGD, females, rural Limpopo

The same situation applies to some of the people who were receiving child support grants and suddenly they no longer did. The following remark provides an example.

We have a problem here in our area, we are told that children over seven years of age are no longer eligible for the grant and what we know is that it has been increased up to 15 or 14 years, but it has not been increased. I have also been earning my child's grant, they have recently cut it because he is seven.

FGD, females, rural Eastern Cape

This reflects that some people have been misinformed about increasing the age of children who are eligible for government support grant. It appears that people have no clear idea of exactly when the new policy regarding age will be put in place. People have high expectations about that issue and they are confused and think that the government is unable to deliver what they have promised.

There was a great concern from some of the female participants about getting access to government grants. They indicated that some of them do not have relevant documents like ID documents or certificates to apply for the grants. It was reported that many children have been left without proper homes because their parents have died and they have no one to look after them and no relatives to help them. They have been told to register at welfare but first they must have certificates. Here are two examples.

No, there is nothing the government helps with. For example, I am not receiving pension because they say I am under age. My daughters' children are also not earning because they say they have passed the required age. The small children who qualify have a problem because their father lives in Johannesburg and they do not have certificates. The government would have supported them if they had certificates.

IDI, female, semi urban, KwaZulu-Natal

There are three children who were staying with their mother and now she is dead and the children taken care of by their aunt. Myself and another lady took them to social workers to register them for the grant but they needed their mother's death certificate. When I called their aunt, she refused to give us the certificate and said that we should not bother ourselves because the children depend on her but she is not making attempts to get them the grant

FGD, females, urban Eastern Cape

There were also complaints that the government is not helping. Apparently this was attributed to the restrictions that are placed in accessing those grants and pensions or even food parcels. These are some of the experiences that other respondents reported in terms of their difficulties in receiving government support.

The government helps but some people are disregarded because civic members write the names of those they choose, not all who need help.

FGD, females, rural Limpopo

They tell you to go to social workers and when you get there, they will tell you to go to the doctor in hospital and the doctor tells you to go back to the social workers and you end up going up and down not getting anything straight but just wasting money or they tell you at hospital that there is no doctor who deals with pension applications.

FGD, females, urban Eastern Cape

I have been through that process of applying for government support but the response I got from the social worker who attended my case was that they only deal with people with TB or the disabled, not normal people like me and I must go and seek for a job. What is amazing is where to go because there is no job everywhere.

FGD, females, rural Eastern Cape

I had a pension from 1998 up to now because I have been sick of kidneys so doctor van Wyk told me not to work any further that is why I've been pensioning. But now I have to revive it and I have been trying to reply but no response has yet been sent to me. In the meantime I used to have a minor job at school where I serve children with food, but before I was working in Tshikeri. My brother does not work but his wife does and she gets paid on a weekly basis, R100, so my brother does not have anything to say because he does not work.

FGD, adult females, rural Eastern Cape

I don't have parents, I have children. Having no family, depending on the little money that I get from the vegetables because I am selling vegetables from my garden. I depend on my garden even today as old as I am. I don't get the pension fund; they said I am under age so I cannot get it. I must work for myself. I share everything with my neighbours because they also don't have parents, I am living with them like my children. The government said I should seek for a job. I went three times to ask for pension fund, they told me to go and look for a job. The government does nothing.

FGD, females, rural Limpopo

There were some of the respondents in areas around the Eastern Cape who mentioned that they applied for the government grants but have not received anything yet. For instance one female respondent reported that she applied for the grant for

the sickly because she is suffering from veins. She applied in 1998 till now, she has been going to doctors and they said she should apply for the grant and every time she does, she doesn't get any reply. This finding somehow is questionable because people are supposed to be informed if their applications have been declined but in this case it appears that those channels are not followed properly.

While some people felt that the government is really trying to assist, there were others who believed that is not the case. For instance there was a male respondent who stays with his son who complained that the government support is only meant for females and does not consider the child but it is about the mother. Here is one statement from a male respondent.

> They told me I must work for my son because grants are for women not fathers. Since I'm living with my son I am expected to work for him but if I had been a woman I would have known that come month end I will be getting the grant. So the child suffers just because I am a man.
>
> **FGD, adult males, rural Eastern Cape**

Some of the respondents form the Eastern Cape indicated that they are making efforts to get relevant documents so that they can apply for government support. However, others are not well informed about such issues, for example one female indicated,

> I do not know how to go about applying for the school grant. Had I knew I would have applied for the one I told you about that she dropped out from standard ten. She would not be sitting and doing nothing as she is now.
>
> **IDI, female, rural Eastern Cape**

On the other hand some respondents felt that some of the social workers do not make efforts to assist them because even if people approach them and tell them about their problems they tell them they cannot help. In other areas it was mentioned that social workers are very seldom seen and people never even hear about their visits. In the Eastern Cape there are those people called *onomakhaya* in some communities who are supposed to act as a link between social workers and the community. However, people complained that these people are inefficient at their jobs.

Others also commented that they couldn't get the food parcels that are supposed to be given to poor households. For example one respondent indicated,

I heard about food from social workers but I have never got it because we have no social workers here as I have said earlier on. We just hear about it from a distance, it's happening in some places that are in other areas.

IDI, male, rural Eastern Cape

There were great concerns from respondents in Limpopo (especially the elderly who are taking care of their grandchildren) about the grants that government is giving to unmarried mothers for child support. They acknowledge the support from government but their main problem is that money is usually not used for supporting the children. The following illustrates some of those concerns.

Children who have children make our life difficult because we are retired, we are pensioners, we live with them, they give birth in a manner that is unacceptable. It is difficult because the child becomes mine, no longer belongs to the mother. Even though the government gives them money, these mothers buy cell phones, do hairstyles or spend the money with their boyfriends.

FGD, adult males, urban Limpopo

There was another major issue that came up during the interviews about the grants. It appears that young ladies decide to fall pregnant because they know that they will get money for that child. The following are some of the comments.

A person gave birth because there is money, so they must give birth, if the child is over age, she gets pregnant again so that she will continue to get the grant.

FGD, males, urban Limpopo

According to me government has done a mistake by giving these people money because if they have money, they keep on giving birth to more children. And now still they have increased the years, it will even be worse.

IDI, male, rural Limpopo

The government helps them, it gives them grants and they misuse the money. Those girls buy their own things, do hairstyles and they don't buy food for the children.

FGD, males, urban Limpopo

Other respondents were of the opinion that these grants should be changed as the child support grant is not used appropriately by some mothers. They suggested that the government should provide people with vouchers instead of giving them cash. One respondent said,

They go to shebeens but some don't, they do take care of their children. I think the government must give them vouchers and not money, it must negotiate with Shoprite and other clothing shops so that these girls must go and take food parcels.

IDI, male, urban Limpopo

The above statements indicate some of the unfortunate experiences in some households. Apparently some of the women regard the child support grants as a way of making money: they survive by giving birth. What is sad is that they do not think beyond the present situation to the time when the children are over age and they can no longer get that money. On the other hand some children suffer because their mothers are not taking care of them since they misuse the money they receive from the grants.

10.5 Summary

The above findings indicate that many families are child-headed families and skip-generation families. Some child-headed families receive financial support from family members who are employed. At some point those who are struggling to get any kind of support may get involved in prostitution, especially young women. The role of the extended family in taking care of child-headed families is weakening. Those families headed by grandparents are better off because they survive on the old age pension. These two grants were the most common means of support for families mentioned during the interviews but the money does not appear to be enough for most families.

There was wide acknowledgement of the government support from most participants with concerns that the grants are not entirely enjoyed by the intended recipients. Thus people thought that old age pension and child support grants are misused to a certain extent. With regard to the child support grant there were suggestions that young mothers should be given vouchers and not cash.

The study intended also to find out about any support that non-governmental organizations and community-based organizations provide to those families in need. Unfortunately this area of focus was not covered during discussions.

CHAPTER ELEVEN

CONCLUSIONS AND RECOMMENDATIONS

11.1 Qualitative Study

South African society has undergone social and political transformation in recent times. This has implications for changes in family structure and composition. There are two major areas that have created changes in different types of families in South Africa namely the escalating HIV/AIDS epidemic and the breakdown of the institution of marriage. These two factors, along with others such as poverty and migration, have caused families to diverge from traditional African culture and customs. This study is an attempt to explore these changes from the perspective of the people concerned. It is important to understand the changes taking place and the causes and consequences of these changes so that measures can be designed that can assist families to cope with the changes.

This report presents findings from phase 1 of the research project that aims at understanding the changing family composition and structure in South Africa. Qualitative data was collected from three provinces: KwaZulu-Natal, Eastern Cape and Limpopo. A total of 120 focus groups and 283 individual in-depth interviews were conducted between the months of February and March 2003. The study was only focussed on Africans in those provinces. That is, native speakers of IsiZulu for KwaZulu-Natal, IsiXhosa for Eastern Cape, and Sepedi and Tshivenda for Limpopo. Altogether there were 1,096 people who were interviewed. The sample includes men and women of all ages.

11.2 Key Findings

The findings suggest that different types of families exist in South Africa. However, respondents reported that there was an increase in the following types of families: female-headed families, child-headed families and skip-generation families. The

issue of female-headed families has been discussed in the literature especially the disadvantages of having low family income and the problem of coping with both raising children and dealing with income-generating activities. Limited measures are already in place in South Africa that assist in dealing with female-headed families such as proving them with social grants. Skip-generation families are those which are created when parents (the middle generation) are ill or die and then grandparents have to take care of their grandchildren. The standard of care for children is often compromised because grandparents are often too old to adequately provide for their emotional and physical well-being. Most families headed by the elderly depend on old age pension though the value of the money they get is decreasing because it has to cater for large families. Some grandparents do not qualify for the old age pension because they are not old enough for such a grant.

The study found out that child-headed families do exist and they were visible. In these families, parent(s) have died or, on a few occasions, they have disappeared and left behind only children in the house. Traditionally, the extended family safety nets used to operate by absorbing those children into the extended family set-up. As the magnitude of those families increase, coupled with the economic hardship that many families face, this tradition tends to disappear. The study found families that were headed by the elder sibling who is under fifteen years old. Neighbours or other villagers know these families and in some cases they assist them, but haphazardly. It should be noted that those children who head families are still too young to handle those responsibilities. Children in those families, including their heads, lack emotional and moral support as well as parental guidance. Older children have to drop out of school and consequently engage in criminal activities or girls engage in sexual relations with older men (or become prostitutes) so as to get income to cater for their families. Unfortunately, there is not any social grant that targets this type of family.

Among the changes in the family that have created conflict within African culture and traditions is cohabitation. People who decide to live together as a family without having any legal documents or a customary arrangement. In this

study, cohabitation was reported to be common especially where the woman's family had received cows for *lobola* (bride price). But, it was also reported that there are people that fail to marry because they do not have enough money or property to pay for *lobola*.[6] Cohabitation also appears when divorcees meet other people and decide to live with them without a formal marriage and these sometimes happen to be better families than their original family. Cohabitation might also be forced, by the woman's relatives, on a man who refuses to pay living expenses for his children who do not live with him. Cohabitation, in cases where *lobola* had not been paid, was however deemed "unfair" on the part of the girl's parents who do not "gain" after all that they have done to the girl i.e. rearing her. Cohabitation, especially in cases where *lobola* had not been paid, did not command the full respect of the community.

Migration and mobility in general is another focus area that was discussed during the qualitative study. This is because migration is known to play a significant role in shaping families in South Africa. The majority of men (nowadays even women) used to migrate to urban centres or other places to look for work. They usually leave a family at home and stay away for extended periods of time. Many respondents suggested that families with a migrant worker usually lack dignity because children staying with the mother alone or on their own lack proper guidance. Many of these children indulge in bad behaviour. Extra marital affairs were also reported as a common phenomenon and in some cases men establish a family in the place of work. Participants, women in particular, were concerned that the casual relationships of their spouses at the place of work is a cause of spreading diseases such as HIV/AIDS. In deed, mobility of people has been documented to be one of the main sources of the escalating HIV/AIDS epidemic in South Africa.

Participants were knowledgeable about sexual and reproductive health matters. The majority reported knowledge about sexually transmitted infections including

[6] It is still a tradition in South Africa, as in many other African countries, to pay a bride price (popularly known as *lobola*) as a crucial part of negotiating a marriage with in laws.

HIV/AIDS. However, it was found that knowledge was somewhat limited in the majority of cases when details of the diseases were requested. It was also noted that there is a conflict between knowledge and behaviour. For instance, many people knew about HIV/AIDS and its consequences and yet they were very reluctant to use condoms. Participants reported that many people still do not care about safe sex. This study suggests that translating knowledge into behavioural change should be a priority for the success of any programme intended to have an impact on reducing the levels of HIV/AIDS.

The apartheid government (prior to 1994) used to practise policies of exclusion. This caused large number of Africans not to have access to various health services which were provided by either the state or the private sector. It was the intention of this study to find out what is happening to people nine years after the end of apartheid. In order to meet the high demand for health services in rural areas, provincial governments have either built clinics or provided mobile clinics which bring health services closer to rural communities. However, a number of problems still exist which include inadequate staffing, lack and shortage of medication, shortage of beds and equipment, travelling long distances to health facilities, unaffordable cost of the services, etc. It is a matter of urgency that better and affordable health services are provided to people especially those residing in rural areas. The negative implications of not having health services appropriate to the well-being of the families are enormous.

As a result of problems reported regarding access to health services and the existence of the HIV/AIDS epidemic, it was necessary to collect information on various matters related to illness and death. These include types of illnesses that are common, various ways and means to manage the illnesses, various methods of coping as well as the manner in which funerals are conducted. Participants acknowledged that there were illnesses that are prevalent to old people and some to young people. Whilst old people seem to suffer from preventable and chronic diseases (such as hypertension, diabetes, arthritis, asthma, tuberculosis and eye

problems), young people suffer from sexually related diseases especially HIV/AIDS. When they are afflicted by illness, people employ various ways of managing them. They either go to clinics and hospitals (which are labelled as White man's medicine) or they go to traditional healers.

Funeral costs are reported to be very high. When people die the bereaved family, according to custom, is not supposed to cook until after the funeral. Neighbours, friends and distant relatives are supposed to bring food or cook for themselves and for the bereaved family. However, poverty, urbanisation and high frequency of people dying has reversed such practices which put a lot of pressure on the bereaved family. In addition, there are costs involved such as keeping the body at the mortuary, the cost of the coffin, transport, slaughtering a cow, etc. that are always beyond the reach of the family. However, to a certain extent burial societies help to ensure that people can afford funeral costs. But unemployment, together with the rise in numbers of burials, are threatening to bankrupt many burial societies.

The final analytical chapter (care and support) presents results on the kind of assistance families receive from the community, the government and non-governmental organizations (NGOs). This is particularly important because most families are unable to raise enough income for the family. Families in need get assistance from the community, especially members of the extended family. A good example is that of child-headed families. Members of the community provide help such as giving them food and in some cases giving them piece-meal jobs for exchange of money or food or clothes. But given that most members of the community are also poor, this help is very limited. It can be summarized therefore that support from the community is available to families with problems but it is not well defined and is inadequate.

The government has seven different types of social grants (see Department of Social Development, 2003 and also Appendix A2). These include: old age grant; disability grant; war veterans grant; foster child grant; care dependency grant; child support

grant; and grant in aid. These grants are very useful in assisting families in need. But there are three problems that were discussed during the interviews. First, grants are not known to people. For those who know about them, some do not succeed in getting because the application procedure is very cumbersome. Second, some people who are in need of such grants do not qualify for any of the grants listed. For instance, child-headed families do not qualify for a child support grant because only caregivers or parents are allowed to apply. Another example is that of grandparents who are not old enough to apply for old age grant. A third problem is misuse of the grant money by recipients. Some participants were bitter towards young mothers who apply for the child support grant but use the money for their personal use such as drinking.

11.3 Recommendations

Child headed Families

The study indicates that there are families which need to be given special considerations. The most notable ones are child-headed families. Children are left on their own after the death of parent(s) or after parent(s) disappear from home. As a result older children have to look after their younger siblings creating what is called a child-headed family. It is important for the government to revise the child support grant to include children who are heading families. Since these children are still young, giving them money will not help them much because they are not experienced in dealing with money and, given the unemployment and poverty which currently prevails, their relatives (such as uncles and grandparents) might take that money and use it for other purposes. The grant can therefore be converted into a form of voucher which could then be used to buy them food and clothes as well as to pay for other essentials.

Skip Generation Families

Another type of family that was found not to cope well is the skip-generation family. This is created when parents (the middle generation) are too ill or die or simply leave

home and do not return which leaves grandparents with the duty of having to take care of their grandchildren. In most cases heads of these families are either unemployed or do not qualify for a pension fund because they are not old enough. This type of family should be considered for financial support. It is also important to note that providing money is not enough for child-headed and skip-generation families. They also need emotional and psychological support as well as guidance. The elderly are too old to look after children and on the other hand children are not old enough to deal with the heavy burden of looking after their younger siblings. A concerted effort needs to be made to get social work services involved in providing support for such families. Also, community support (both cultural and religious) in the form of community leaders needs to be involved in the exercise of supporting such families.

Cohabitation

The prevalence of cohabiting couples especially in urban centres seems to be on the increase. With the exception of those who go ahead and pay *lobola* these families are not accepted in African societies. Measures should be designed to encourage people to have formal marriages. This can be done by reducing the amount of *lobola.* We are aware of parents who demand excessive *lobola* such as expensive cars. This is usually the case when a woman is well educated or has a very lucrative job or business. If *lobola* can be standardised so that everyone can afford it, there is a good chance that many men will decide to marry. We argue that proper negotiation with traditional leaders can go a long way in making sure that people understand the concept of *lobola* and hence accept small amounts of money or contributions in kind (as was the case before the colonial intervention).

In cases where cohabitation has to continue, there should be a mechanism to formalize those relationships especially if people cohabit for an extended period of time. In Tanzania, for example, when people cohabit for at least two years, they are considered by law to be legally married. However, there is always a problem of giving proof for such a marriage. We, therefore, suggest that a certificate of marriage needs

to be given to people who cohabit for a certain period of time. This will also assist spouses to inherit money or property in case one dies or to demand support for child rearing.

Costs of funerals

Illnesses and consequently deaths provide a lot of pressure to families particularly during the era of HIV/AIDS. Usually, infected people are income earners and their illness and eventually death reduces the family income. A lot of money is used for their special nutrition and medical expenses and the inevitable funeral costs constitute a major financial burden. In addition, children need care and comfort and they still have to deal with the burden of caring for the sick person(s), which shifts their attention from other day-to-day activities. This implies that the living standard and quality of life of surviving members of the family is adversely affected. What is more surprising is the way families conduct funerals – it is just a very expensive exercise. Dead bodies are kept in the mortuary for extended periods of time costing families a lot of money. During that time, friends, neighbours and relatives stay with the bereaved family and that means providing food and drink for them. The funeral itself costs a fortune. People should be encouraged to organize moderate funerals especially if they cannot afford an expensive one. There is an important role to be played by both cultural and religious leaders as well as the media in this regard.

Care and support for HIV/AIDS affected families

The study has found that people have adequate knowledge of HIV/AIDS. This implies that programmes should be geared to something additional to just disseminating the information. Obviously, there is misconception and various people do not understand exactly what is going on. But there is now a greater need to concentrate on issues related to care of and support for families that have been affected.

Changing sexual behaviour

Another issue that needs to be addressed is that of change of behaviour. Despite the information they have, and the evidence they have seen of people who suffer and eventually succumb to AIDS, many people do not practice safe sex. In other words, the behaviour of having multiple partners still exists and many do not want to use a condom. The special group to target in dealing with HIV/AIDS is perhaps migrant workers who are very mobile and their sexual network is extensive.

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APPENDICES

A.1 FIELDWORKERS

1. KWAZULU-NATAL

Mrs. Sibongile Mkhize - supervisor

Mr. Sibonakaliso Radebe

Ms. Nomusa Mbeje

Mr. Collin Basi

Ms. Sihle Sithole

Ms. Thulile Gumede

Ms. Nomhle Nodola

2. LIMPOPO

Mrs. Damaria Molepo - supervisor

Ms. Tshepo Lekhuleni

Mr. Charles Phasha

Ms. Eva Kgatla

Mr. Thabo Makwela

Mr. Benson Ralipaswa

Ms. Tshilidzi Mulaudzi

3. EASTERN CAPE

Ms. Nomfundo Hoho - supervisor

Mr. Kumbuza Cimi

Mr. Zonwabele Merile

Miss Xolelwa Jack

Miss Zukiswa Mhambi

Mrs Nonkululeko Sandlana

Ms. Pumeza Ntlanganiso

A2. GRANTS PROVIDED BY THE GOVERNMENT OF SOUTH AFRICA (Source: Department of Social Development, 2003).

I. TYPES AND REQUIREMENTS OF SUPPORT GRANTS

1. *OLD AGE GRANT* – Rand 700 per month
The applicant:
- must be a South African Citizen;
- must be resident in South Africa at the time of application;
- if a male, must be over 65 years or older;
- if a female, must be 60 years or older;
- and spouse must comply with the means tests;
- must not be maintained or cared for in a State Institution;
- must not be in receipt of another social grant;
- must submit 13 digit bar coded identity document.

2. *DISABILITY GRANT* – Rand 700 per month
The applicant:
- must be a South African Citizen;
- must be resident in South Africa at the time of application;
- must be between 18 to 59 years of age if a female and 18 to 64 years of age if a male;
- must submit a medical/assessment report confirming disability;
- and spouse must meet the requirements of the means test;
- must not be maintained or cared for in a State Institution;
- must not be in receipt of another social grant in respect of yourself;
- must submit 13 digit bar coded identity document.

3. *WAR VETERANS GRANT* – Rand 718 per month
The applicant:
- must be a South African Citizen;
- must be resident in South Africa at the time of application;
- must be 60 years and over or must be disabled;
- must have fought in the Second World War or the Korean War or served in the war that commenced on 06 September 1939;
- and spouse must meet the requirements of the means test;
- must not be maintained or cared for in a State Institution; and
- must not be in receipt of another social grant.

4. *FOSTER CHILD GRANT* - Rand 500 per month
- the applicant child must be resident of South Africa at the time of application;
- 13 digit bar coded ID document (applicant);
- court order indicating foster care status;
- must have valid RSA/non RSA 13 digit ID number in respect of each child;
- foster child must pass the means test.

5. *CARE DEPENDENCY GRANTS* - Rand 700 Per month
   - must be South African citizen except for foster parents;
   - the applicant and child must be resident in South Africa;
   - age of child must be from 1 to 18 years;
   - must submit a medical/assessment report confirming disability;
   - applicant, spouse and child must meet the requirements of the means test;
   - the care-dependant child/children must not be permanently cared for in a State Institution.

6. *CHILD SUPPORT GRANTS* - Rand 160 per month
   - the child and primary care giver must be a South African citizen and resident in South Africa;
   - applicant must be the primary care giver of the child/ children concerned;
   - the child/ children must be under the age of 9 years;
   - the applicant and spouse must meet the requirement of the means test;
   - 13 digit bar coded ID document (of the care giver); and
   - 13 digit birth certificate (of the child);
   - can not apply for more than six non biological children.

7. *GRANT IN AID* - Rand 150 per month
   - must require full time attendance by another person owing to his/her physical or mental disabilities;
   - must not be cared for in an institution that receives subsidy by the state for the care housing of such beneficiary;
   - must be a social grant recipient.

A grant in aid is a grant awarded to person who are in receipt of an (Old age/Disability/War Veteran's Grant), and who are unable to care for themselves.

II. ADDITIONAL INFORMATION ABOUT THE GRANTS

WHAT IS A MEANS TEST?

The most important factor when a person applies for social assistance is his/ her financial position. The reason for this is that grants are only awarded if the applicant's financial resources are below a certain level. In determining when applicant qualifies for a grant, and if so, to what amount he/she would be entitled, the income and assets of the applicant and spouse or the concerned foster child are assessed.

WHERE DO YOU APPLY FOR A GRANT?

- You apply at the Welfare Office nearest to where you live;
- If you are too old or sick to travel to the office to apply for a grant, then a family member or friend can apply on your behalf;

-Your application form will be completed in the presence of an officer from the department;
- When your application is completed you will be given a receipt;
- Keep this receipt-it is your only proof of application;
- You do not have to pay any money to apply;
- If your application is not approved by the Welfare office, you must be informed in writing as to why your application was unsuccessful;
- You have the right to appeal to the Minister for Welfare in your Province in writing, explaining why you disagree with the decision. This appeal must be lodged within 90 days of notification of the outcome of your application.

DATE OF AWARD OF GRANTS
If your grant is approved, you will be paid from the day you applied.

IF YOUR APPLICATION FOR A GRANT IS UNSUCCESSFUL
The applicant must be informed in writing of the reasons for the refusal of the grant, and his/her right to appeal within 90 days of notification.

METHODS OF PAYMENT
You receive your grant by the following methods:

- Cash payments
- Banks
- Post Office
- Institution

Note: If you are unable to collect the grant yourself you may nominate a procurator to regularly collect it for you.

SUSPENSION OF GRANTS
The following may result in the suspension of a grant:

- Changes in circumstances;
- outcome of a review;
- failure to co-operate when a grant, reviewed.

RESTORATION OF GRANTS
An application must be made for restoration of a grant within 90 days of the suspension.

MAIN REASON FOR LAPSING OF GRANTS

- death;
- admission to a State Institution;
- if the grant is not claimed for 3 consecutive months;
- when the period of temporary disability has lapsed;

- you are absent from the Republic for a continuous period longer than six months.

REVIEWS

You must declare any income at the time of application. This will form the basis on which the department will decide whether your grant must be reviewed. You will be notified 3 months in advance of the date of the review or the date on which the life certificate is due.

SOCIAL RELIEF OF DISTRESS

Social relief of distress is a temporary provision of assistance intended for persons in such dire material need that they are unable to meet their or their families most basic needs.

In order to qualify for Social Relief of distress, the applicant must comply with one or more of the following conditions:

- the applicant is awaiting permanent aid;
- the applicant has been fond medically unfit to undertake remunerative work for a period of less than 6 months;
- the breadwinner is deceased and insufficient means are available;
- the applicant has been affected by a disaster, and the specific area has not yet been declared a disaster area; and
- the applicant has appealed against the suspension of his or her grant;
- the person is not a member of a household that is already receiving social assistance;
- the person is not receiving assistance from any other organization.

PERIOD OF SOCIAL RELIEF OF DISTRESS

Social Relief of Distress is issued monthly or for any other period for a maximum period of 3 months. Extension of period by a further 3 months may be granted in exceptional cases.

Transport expenditure maybe paid in exceptional cases where;

- the applicant is referred for treatment by a medical officer and no other transport arrangements can be made; and
- the applicant must travel to a specific destination to accept employment where he or she will not be dependent on further State Aid.

A.3 RESEARCH INSTRUMENTS

1. FOCUS GROUP DISCUSSION GUIDE

INTRODUCTION

I would like to thank you for agreeing to be interviewed. My name is (name of fieldworker) and I am from the School of Development Studies and am conducting interviews as part of a research project on Understanding the Changing Family Composition and Structure. *(Moderator: Introduce any other fieldworker present)* We are here to study the various challenges facing families today. This study is being conducted by researchers from the University of Natal *(in collaboration with the local University and the provincial government)* for the United Nations Population Fund. We feel that by talking to people like you we can best find out about your activities, opinions and feelings about these issues. There are no wrong or right answers, we are interested in your views, so please feel comfortable to say what you honestly feel. I have a list of topics I would like us to talk about but please feel free to bring up any other issues you feel are relevant.

During the discussion, we will be taking notes to keep track of what has been covered, and to remind us if we forget to ask certain things. However, so that we do not to have to worry about getting every word down on paper, we will also be recording the whole discussion. The recording is only to help us remember what you said. As soon as the tape has been transcribed, what you said will be erased, so no one will know who said what. Please note also that your names and any information which identifies you and your households and families will not appear in our reports.

Regarding the language we want you to feel comfortable throughout the discussion, so please just use the language that you use when you chat with friends. Finally, please try to let everyone have a turn at saying something, all your views are important, and please try to keep the talk within the group.

The discussion is strictly confidential.

1. ICE BREAKER

1.1 Self introduction – name only
1.2 Background information about the family e.g. how many people in the family, number of dependants, etc.

2. DEFINITION OF TERMS

2.1 How do you understand the term family/household?
2.2 Mention different types of families/households you know
2.3 Who is the head of family/household?
2.4 Why choose that individual to be the head?
2.5 In your opinion, who is supposed to be head of a family/household? Give reasons

3. TYPES OF FAMILIES IN THE AREA

3.1 List different types of families in the area/village
3.2 What is their structure?
3.3 What is their composition?
3.4 What is your opinion on different types of families you know?
3.5 Have you observed any changes of different family types overtime? Explain
3.6 Do you know the reasons for those changes?

4. HEADS OF FAMILIES

4.1 Who are heads of families in area - men or women?
4.2 Why do you think that is?
4.3 How do such families fare, compared to other families?
4.4 Why do you think that is?
4.5 How old would you say the family heads are?
4.6 Are you aware of families where unmarried men and women are raising children?
4.7 What would you say are the causes of such families?
4.8 How do such families fare, compared to other families?

5. PARTNERSHIP PATTERNS

5.1 Describe different partnership patterns that exist in your area
5.2 In your opinion, how do you think they come to exist?
5.3 Is there any difference of these partnerships by age / gender?
5.4 What do you think will be the reason?

6. CHILD HEADED FAMILIES

6.1 Do you know of any child-headed families in your area?
6.2 What were the circumstances that led to the families being headed by children?
6.3 What is the structure of your family?
6.4 What is the composition of your family?
6.5 How do such families make ends meet?
6.6 Is there anything that your community does to help such families?
6.7 Is there anything that the government is doing to help such families?
6.8 Is there anything that can be done to help such families?

7. SKIP GENERATION FAMILIES

7.1 Are you aware of families where grandparents are raising grand-children?
7.2 What would you say are the causes of such families?
7.3 How do such families make ends meet?
7.4 How do the community cope with such families?

8. MIGRATION

8.1 Are there any families with migrant workers in your area?
8.2 In most cases, who are the migrants (men or women)?
8.3 Normally, how long do migrant workers take before they visit home?
8.4 Who normally takes responsibility for the family when the migrants are away?
   a. Who takes care of the house?
   b. Who pays school fees?
   c. Who buys the food?
   d. Who makes day-to-day decisions?
8.5 What is the impact of migrant labour on the families?
8.6 Is there anything that the community does to assist families of migrant labourers?
8.7 Is there anything that the government is doing to assist such families?

9. SCATTERED FAMILIES

9.1 Give details of the living arrangements of members of the family
9.2 Where do you consider home and why?
9.3 Whom do you consider head of family and why?
9.4 What is the role of the head of family?
9.5 How do you cope in difficult circumstances?
9.6 What is your opinion on scattered families?

10. MORBIDITY

10.1 Which forms of illnesses do people in your area complain about?
10.2 Why do you think this is the case?
10.3 Would you say that there are illnesses that disproportionately affect young people and those that affect older people?
10.4 Mention those that affect young people and those that affect older people
10.5 What do people do to deal with or cure such illnesses?
10.6 What do families do to deal with or cure such illnesses?
10.7 Do they go to hospitals or clinics to get the illnesses cured?

11. MORTALITY

11.1 Are you aware of any deaths in your area?
11.2 What are the major causes of death in your area?
11.3 Why do you think this is the case?
11.4 How old are people at death?
11.5 How are funerals carried out in the area?
11.6 Can most families afford the funeral costs?
11.7 Is there anything that neighbours do to help towards funeral costs?

12. SEXUALITY AND REPRODUCTIVE HEALTH

12.1 Do young unmarried people have boy/girl friends in this area?
12.2 What is your opinion on people having sexual relationships outside marriage?
12.3 Do you discuss sexual related matters with your children / friends?
12.4 If yes, what exactly do you discuss? Probe
12.5 Are there family planning (FP) clinics in your area?
12.6 Do you visit FP clinics?
12.7 What services are offered in those FP clinics?
12.8 Are these services adequate?
12.9 Do you think young people are discriminated in getting access to reproductive health facilities? Probe
12.10 In your opinion, what are the major challenges / set backs of the FP clinics?
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13. HIV/AIDS

13.1 Do you know illness called AIDS?
13.2 How does one happen to suffer from AIDS? Probe
13.3 Are there people in your area who suffer from AIDS?
13.4 Do such people have access to any medication?
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13.8 Do you know anything about HIV? Explain
13.9 What is the relationship between HIV and AIDS?

14. CONCLUSION

We are reaching the end of the discussion. Does anyone have anything to add before we turn off the tape? I think it went well. Do any of you have any comments on how you feel it went?

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BACKGROUND INFORMATION OF PARTICIPANTS

Member	Gender[i]	Age	Relation[ii]	Education[iii]	Marital[iv]	Vocation[v]	Occupation[vi]	Income	Source[vii]

1 Gender	2 Relationship to Hhh	3 Highest School Education Completed	4 Marital Status	5 Vocational Status	6 Occupational Category (Formal)	7 Source of Income
1 Male 2 Female	1Household Head 2 Spouse 3 Son 4 Daughter 5 Sister 6 Brother 7 Parent 8 Grandchild 9 Other Relative	0 No Education 1 Grade One 2 Grade Two 3 Std 1-10 4 NTC 1 5 NTC 2 6 NTC 3 7 Beyond NTC 3	1 Married 2 Single 3 Divorced 4 Widowed 5 Deserted 6Living Together 7 Other	1 Student 2 Not Econ Active 3 Retired 4 Disabled 5Unemployed (n.seek) 6Unemployed (seek) 7 Employed (Inf.) 8 Self Employed (Inf.) 9Employed (Formal) 10Self Employed (Formal) 11Part-Time Employed 12 Other	1 Labourer 2 Domestic 3 Technician/Artisan 4 Clerical 5 Police/Security/Army 6 Managerial 7 Professional 8 SemiProfessional 9 Driver 10 Supervisor 11 Shop Assistant 12 Waiter/Cook/Porter 13 Other	1All Monthly Formal Earnings 2All Monthly Informal Earnings 3Average Pension/Welfare Monthly 4 Remittances 5 Contributions (if Earnings Unknown) 6 Grants 7 Other ..

2. INDEPTH INTERVIEW GUIDE

INTRODUCTION

I would like to thank you for agreeing to be interviewed. My name is (name of fieldworker) and I am from the School of Development Studies and am conducting interviews as part of a research project on Understanding the Changing Family Composition and Structure. We are here to study the various challenges facing families today. This study is being conducted by researchers from the University of Natal *(in collaboration with the local University and the provincial government)* for the United Nations Population Fund. We feel that by talking to people like you we can best find out about your activities, opinions and feelings about these issues. There are no wrong or right answers, we are interested in your views, so please feel free to say what you honestly feel. I have a list of topics I would like us to talk about but please feel free to bring up any other issues you feel are relevant.

During the discussion, we will be taking notes to keep track of what has been covered, and to remind us if we forget to ask certain things. However, so that we do not to have to worry about getting every word down on paper, we will also be recording the whole discussion. The recording is only to help us remember what you said. As soon as the tape has been transcribed, what you said will be erased, so no one will know who said what. Please note also that your names and any information which identifies you and your households and families will not appear in our reports.

Regarding the language we want you to feel comfortable throughout the discussion, so please just use the language that you use when you chat with friends.

The discussion is strictly confidential.

1. ICE BREAKER

1.1 Self introduction – name only
1.2 Background information about the family e.g. how many people in the family, number of dependants, etc.

2. DEFINITION OF TERMS

2.1 How do you understand the term family/household?
2.2 Mention different types of families/households you know
2.3 Who is the head of family/household?
2.4 Why choose that individual to be the head?
2.5 In your opinion, who is supposed to be head of a family/household? Give reasons

3. TYPES OF FAMILIES IN THE AREA

3.1 List different types of families in the area/village
3.2 What is their structure?
3.3 What is their composition?
3.4 What is your opinion on different types of families you know?
3.5 Have you observed any changes of different family types overtime? Explain
3.6 Do you know the reasons for those changes?

4. HEADS OF FAMILIES

4.1 Who are heads of families in area - men or women?
4.2 Why do you think that is?
4.3 How do such families fare, compared to other families?
4.4 Why do you think that is?
4.5 How old would you say the family heads are?
4.6 Are you aware of families where unmarried men and women are raising children?
4.7 What would you say are the causes of such families?
4.8 How do such families fare, compared to other families?

5. PARTNERSHIP PATTERNS

5.1 Describe different partnership patterns that exist in your area
5.2 In your opinion, how do you think they come to exist?
5.3 Is there any difference of these partnerships by age / gender?
5.4 What do you think will be the reason?

6. CHILD HEADED FAMILIES

6.1 Do you know of any child-headed families in your area?
6.2 What were the circumstances that led to the families being headed by children?
6.3 What is the structure of your family?
6.4 What is the composition of your family?
6.5 How do such families make ends meet?
6.6 Is there anything that your community does to help such families?
6.7 Is there anything that the government is doing to help such families?
6.8 Is there anything that can be done to help such families?

7. SKIP GENERATION FAMILIES

7.1 Are you aware of families where grandparents are raising grand-children?
7.2 What would you say are the causes of such families?
7.3 How do such families make ends meet?
7.4 How do the community cope with such families?

8. MIGRATION

8.1 Are there migrant workers in your family?
8.2 How are you related to the migrant worker?
8.3 Normally, how long do migrant workers take before they visit home?
8.4 Who normally takes responsibility for the family when the migrants are away?
   a. Who takes care of the house?
   b. Who pays school fees?
   c. Who buys the food?
   d. Who makes day-to-day decisions?
8.5 What is the impact of migrant labour on your family?
8.6 Is there anything that the community does to assist families of migrant labourers?
8.7 Is there anything that the government is doing to assist such families?

9. SCATTERED FAMILIES

9.1 Give details of the living arrangements of members of the family
9.2 Where do you consider home and why?
9.3 Whom do you consider head of family and why?
9.4 What is the role of the head of family?
9.5 How do you cope in difficult circumstances?
9.6 What is your opinion on scattered families?

10. MORBIDITY

10.1 Which forms of illnesses do people in your area complain about?
10.2 Why do you think this is the case?
10.3 Would you say that there are illnesses that disproportionately affect young people and those that affect older people?
10.4 Mention those that affect young people and those that affect older people
10.5 What do people do to deal with or cure such illnesses?
10.6 What do families do to deal with or cure such illnesses?
10.7 Do they go to hospitals or clinics to get the illnesses cured?

11. MORTALITY

11.1 Are you aware of any deaths in your area?
11.2 What are the major causes of death in your area?
11.3 Why do you think this is the case?
11.4 How old are people at death?
11.5 How are funerals carried out in the area?
11.6 Can most families afford the funeral costs?
11.7 Is there anything that neighbours do to help towards funeral costs?

12. SEXUALITY AND REPRODUCTIVE HEALTH

12.1 Do young unmarried people have boy/girl friends in this area?
12.2 What is your opinion on people having sexual relationships outside marriage?
12.3 Do you discuss sexual related matters with your children / friends?
12.4 If yes, what exactly do you discuss? Probe
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